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90-640

No. _____



In The

# Supreme Court of the United States

October Term, 1990

MARY JANE WICKMAN,

*Petitioner,*

v.

NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY,

*Respondent.*

## PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

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## QUESTIONS PRESENTED

(1) Where an employer purchases a group life insurance policy providing accidental death benefits (with an exclusion for suicide) does ERISA pre-empt a contract claim for those benefits where the insurer failed to provide the required §1133 notice and otherwise made no effort to comply with ERISA or its regulations?

(2) Assuming ERISA applies, where the insurer refuses to pay accidental death benefits because of the suicide exclusion, should the federal common law in construing the term "accident" ignore the state law presumption as to suicide and the *prima facie* effect of the death certificate, and adopt a new version of the discredited accidental means/accidental result test?

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## PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

Petitioner, Mary Jane Wickman, respectfully requests that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the First Circuit.

## OPINIONS BELOW

The reported opinion of the United States Court of Appeals For The First Circuit, Mary Jane Wickman v. Northwestern National Life Insurance Company (*Wickman v. Northwestern Nat. Ins. Co.*, 908 F.2d 1077 (1st Cir. 1990)), affirming Magistrate Collings, is reproduced in Appendix A (1a-28a).

The unreported opinion of Magistrate Collings denying Mary Jane Wickman's claim for accidental death benefits is reproduced in Appendix B (1b-15b).

The unreported opinion of Magistrate Collings finding that Mary Jane Wickman's contract action was preempted by ERISA is reproduced in Appendix C (1c-19c).

## STATEMENT OF JURISDICTION

The opinion of The United States Court of Appeals For The First Circuit denying Mary Jane Wickman's claim for accidental death benefits was filed on July 20, 1990. Jurisdiction of the Court is invoked pursuant to 28 U.S.C. §1254(1) and Rules of This Court, Rules 10 and 14.

## STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant part of ERISA, 29 U.S.C. §§1001 et seq., provides:

> 29 U.S.C. §1002(1) defines an "employee welfare benefit plan" as including "any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, death or unemployment, or vacation

benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions)."

. . . .

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

. . . .

29 U.S.C. §1102 Establishment of plan:

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(2) For purposes of this subchapter, the term "named fiduciary" means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly.

(b) Requisite features of plan

Every employee benefit plan shall –

(1) provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of this subchapter,

(2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan (including any procedure described in section 1105(c)(1) of this title),

(3) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan, and

(4) specify the basis on which payments are made to and from the plan.

"§1132. Civil enforcement.

(a) Persons empowered to bring civil action

A civil action may be brought –

(1) By a participant or beneficiary

. . . .

(B) To recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

. . . .

(3) By a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of this plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;" 29 U.S.C. §1132(A).

Section 1133 of ERISA provides:

In accordance with regulations of the Secretary, every employee benefit plan shall –

(1) provide adequate notice in writing to any participant or beneficiary whose claim for

benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

The Secretary of Labor's regulations provide:

A plan administrator or, if paragraph (c) of this section is applicable, the insurance company, insurance service, or other similar organization, . . . shall provide to every claimant who is denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

29 C.F.R. §2560.503-1(f)(1989).

29 U.S.C. §1022 Plan Description and Summary Plan Description (for full text, see Appendix D).

29 U.S.C. §1023 Annual Reports (for full text, see Appendix E).

## STATEMENT OF THE CASE

This case began as a diversity breach of contract claim instituted by Mary Jane Wickman (Mary Jane) to recover accidental death benefits due to her from Northwestern National Life Insurance Company (Northwestern)[1] which had issued a group life insurance policy to her husband Paul's employer. Northwestern declined to pay the benefits claiming that the cause of death of Paul Wickman (Paul) was suicide and persisted in this view despite being presented with the Amended Death Certificate, (which constituted *prima facie* evidence of the cause of death under state law) which stated the "cause of death" to be "massive internal hemorrhage secondary to fracture – dislocation of pelvis – caused by 90 foot fall from bridge." (E. 7, P. Ex. 4).

Fourteen months after suit was instituted, Northwestern moved to dismiss on the ground that the contract action was preempted by the Employee Retirement Income Security Act of 1974 (ERISA) relying upon *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549 (1987) and *Metropolitan Life Insurance Company v. Taylor*, 481 U.S. 58, 107 S. Ct. 1542 (1987). Despite the fact that Northwestern expected claims under its contract[2] with

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[1] There is no parent or subsidiary company to be listed.

[2] The group contract issued to Paul's employer (Paul received only a certificate – he never saw the group policy) stated: "This group policy is delivered in the state of Connecticut and is governed by its laws." (A. 33).

Paul's employer to be subject to state law and that the supervisor who denied Mary Jane's claim had no idea that Northwestern was a fiduciary under ERISA, on October 22, 1987, the Magistrate granted the defendant's motion to dismiss (see Appendix C for the text of the opinion) and leave was granted to amend the complaint. The amended complaint asserted a contract claim (Count I) and also a claim under ERISA. Pursuant to its October 27, 1987 Memorandum (Appendix C), Magistrate Collings dismissed Count I of the amended complaint.

With the consent of counsel the ERISA claim proceeded to a non-jury trial before him on February 8-11, 1988. More than twenty months later, Magistrate Collings on October 23, 1989, entered Findings of Fact and Conclusions of Law and judgment for the defendant. (See Appendix B).

Ironically, although Northwestern asserted at trial that it was a fiduciary under ERISA and that Mary Jane could only proceed under ERISA, the Northwestern Supervisor (Diane Yell (Yell)), who denied the claim, stated that she was unaware of Northwestern's fiduciary duties under ERISA. Indeed, although she had heard of the term ERISA, she did not know what it stood for. (3 Tr. 34). Yell also explained that in handling the Wickman claim she was acting on behalf of Northwestern, and that it never came to her attention that ERISA might apply to the claim. (3 Tr. 30, 38, 40). Since Northwestern was unaware of its fiduciary duties, it was also unaware of all the regulations and other requirements of ERISA with which it, of course, never complied. Moreover, Northwestern never produced the written instrument required by 29 U.S.C. §1102 for creation of an "employer benefit

plan." It is impossible to tell from the record whether or not Northwestern's insurance policy is even a part of an "employee welfare benefit plan," particularly when the life insurance policy 1) does not "provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan," 2) does not "provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan," 3) does not "describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan," 4) does not "provide a procedure for amending such plan and for identifying the persons who have authority to amend the plan," and fails to comply with the 29 U.S.C. §1133 and 29 C.F.R. §2560.503-1 mandate for reviewing initially denied claims. Nevertheless, the Magistrate held that where there are periodic premium payments by the employer, the mere purchase of an insurance policy establishes an ERISA plan. (Appendix C at 12c).

Although Northwestern had disclaimed on the basis of suicide and agreed at trial that Paul's death was either accident or suicide, the Magistrate found it was *neither* accident nor suicide because:

> " . . . assuming that Mr. Wickman had no specific intent to injure or kill himself, the Court finds that he intentionally put himself outside the guard rail on the bridge over the railroad tracks and, further, that the harm that befell him was substantially certain to happen." (Appendix B at 11b).

Accordingly, the Magistrate ruled that Northwestern "has neither breached its contract nor breached its fiduciary

duties with respect to the denial of accidental death benefits to Mrs. Wickman" (Appendix B at 13b) and therefore entered judgment for the defendant. (Appendix B at 14b).

On appeal the United States Court of Appeals for the First Circuit, although stating that the mere purchase of an insurance policy is insufficient, found that a "plan" had been established because the purchase of the insurance policy constituted "an expressed intention by the employer to provide benefits on a regular and long term basis." (Appendix A at 11a). In determining what standard the federal common law under ERISA should adopt, the First Circuit rejected the parties' agreement at trial that Paul's death was due to accident or suicide. Instead, while eschewing the accidental means/accidental results distinction criticized by Justice Cardozo in *Landress v. Phoenix Mutual Life Ins. Co.*, 291 U.S. 491, 499 (1934), the First Circuit relied on jurisdictions which still follow this discredited rationale to formulate a new version. The First Circuit created a dual test. A subjective test of the "reasonable expectation of the insured" should be applied. However, "if the fact-finder, in attempting to ascertain the insured's actual expectation, finds the evidence insufficient to accurately determine the insured's subjective expectation, the fact-finder should then engage in an objective analysis of the insured's expectations." (Appendix A at 25a). The First Circuit also noted that "[b]ecause the magistrate decided there was no accident in this case, and we affirm on this basis, he did not and we need not reach the question of whether Wickman's death was actually a suicide," (Appendix A at 25a n.5)

thereby apparently creating an unprecedented middle ground[3] between accident and suicide for ERISA claims.

## REASONS FOR GRANTING THE WRIT

The question of when an insurance company should be protected by ERISA from a garden variety life insurance contract claim under state law is an important question of federal law which has not been, but should be, settled by this Court. The lower courts are in conflict concerning when the purchase of an insurance policy constitutes establishment of an ERISA plan. Even if the "plan" in the case at bar is sufficient to warrant preemption, according to the First Circuit Court of Appeals the case "presents a question of first impression under the Act [ERISA] concerning the interpretation of life insurance contracts." (Appendix A at 1a).

## ARGUMENT

### I. The Lower Courts Are In Conflict Concerning When The Purchase Of An Insurance Policy Constitutes The Establishment Of An ERISA Plan.

In *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 107 S. Ct. 2211 (1987) this Court concluded that an evaluation of both the express terms of ERISA and the legislative intent

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[3] Since Paul obviously did not die of natural causes, the judicial determination that death did not occur through accident or suicide leaves the actual cause of death somewhat of a mystery.

shows that ERISA only preempts state laws relating to employee benefit *plans*, and not state laws merely relating to employee *benefits*. This Court further explained that ERISA was enacted to require disclosure and provide safeguards with respect to the establishment, operation, and administration of employee benefit plans; to prevent abuses of the special responsibilities borne by those dealing with the plans; and to prevent self-dealing, imprudent investing, and misappropriation of plan funds. According to *Fort Halifax*, since the focus of the statute is on the administrative integrity of benefit plans, it presumes some type of administrative activity is taking place. Thus, this Court concluded that only "plans" involving administrative activity potentially subject to *employer* abuse are subject to ERISA preemption:

> "Statements by ERISA's sponsors in the House and Senate clearly disclose the problem that the preemption provision was intended to address." *Id.*, ___ U.S. ___, 107 S. Ct. at 2216.
>
> "These statements reflect recognition of the administrative realities of employee benefit plans. An *employer* that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements." *Id.*, ___ U.S. ___, 107 S. Ct. at 2216. (emphasis added).

Clearly, when an employer has merely purchased an insurance policy, it has relieved itself of a need to determine eligibility, calculate benefits, make disbursements,

monitor the availability of funds, or keep records to comply with reporting requirements. *Fort Halifax*, 482 U.S. at 9, 107 S. Ct. at 2216. Hence the reason behind preemption of having uniform regulation of the administration of employee benefit plans disappears when the employer's sole role is to send a premium to an insurance company, at least where the insurer fails to comply with ERISA regulations or otherwise act as if ERISA applied. The safeguards imposed by ERISA are worthless and the insurance company gets the benefit of ERISA's limited remedies without taking on any of ERISA's responsibilities. See *Fort Halifax*:

> "The third answer to appellant's argument is that the Maine statute not only fails to implicate the concerns of ERISA's preemption provision, it fails to implicate the *regulatory concerns of ERISA* itself. The Congressional declaration of policy, codified at 29 U.S.C. §1001, states that ERISA was enacted because Congress found it desirable that *disclosure* be made and *safeguards* be provided with respect to the establishment, operation, and administration of [employee benefit] plans." §1001(a). *Id.*, 482 U.S. 15, 107 S. Ct. at 2219 (emphasis added).

Since *Pilot Life*, the federal courts have been greeted with the unseemly spectacle of insurance companies seeking the protection of ERISA preemption against state law claims. (In *Pilot Life* the parties assumed that an ERISA plan existed and this court had no occasion to decide the circumstances under which the purchase of a group policy should be deemed to establish an ERISA plan). The concern of Congress in enacting ERISA was

not to protect insurers against state law claims (especially, as here, contract claims which they fully anticipated), but rather to protect employees and their beneficiaries. The lower courts have expressed concern at this anomalous development. See e.g., *Jordan v. Reliable Life Ins. Co.*, 694 F. Supp. 822, 835 (N.D. Ala. 1988) ("Only Congress or the Supreme Court can rescue us from the [ERISA] quicksand") and *In re Volpe*, 100 B.R. 840, 842 (Bkrtcy. W.D. Tex. 1989) (same).

The lower courts are in conflict concerning when an employer's purchase of group insurance is a sufficient ERISA plan to trigger preemption. See e.g. *Rizzi v. Blue Cross of So. California*, 206 Cal. App. 3d 380, 393-394, 253 Cal. Rptr. 541, 550 (1988), cert. denied 110 S. Ct. 78 (1989) ("The court [in Pilot Life] reasoned that the civil enforcement scheme (§1132, subd. (a) was one of the essential tools for accomplishing ERISA's stated purposes, along with the provision requiring every employee benefit plan to give notice to a beneficiary whose claim has been denied and an opportunity for review (§1133), and a provision authorizing criminal penalties for violations of reporting and disclosure provisions (§1131).") and *DePina v. General Dynamics Corp.*, 674 F. Supp. 46 (D. Mass. 1987) (ERISA regulations require written notice to a participant or beneficiary whose claim for benefits under a plan have been denied and a reasonable opportunity for full and fair review of the decision denying the claim). Here not only did the insurer fail to provide any notice to the beneficiary of an opportunity to review denial of her claim, but also the person denying the claim did not even know that she was acting in a fiduciary capacity. Indeed, Northwestern's Supervisor did not even know what the

term "ERISA" stood for and despite Northwestern's claim at trial that she was acting as a fiduciary she stated that she was acting on behalf of Northwestern. (3 Tr. 34, 38). It had never even come to her attention that ERISA might apply to the claim! (3 Tr. 30, 38, 40).

Nevertheless, the First Circuit held that

> "[t]he crucial factor in determining if a 'plan' has been established is whether the purchase of the insurance policy constituted an expressed intention by the employer to provide benefits on a regular and long term basis." (Appendix A at 11a).

Although there was no evidence of a contract between Paul's employer and its employees requiring the employer to purchase life insurance on behalf of the employees, the First Circuit found indicia of long term intent despite the fact that group life insurance is purchased on an annual basis. The First Circuit also relied on the *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) standard that the employee be able to ascertain the procedures for receiving benefits. Since all insurance policies contain a procedure for receiving benefits, this test is unhelpful for distinguishing between situations in which the mere purchase of insurance is insufficient to establish a "plan" and those in which it is.

No satisfactory test has been formulated by the lower courts for determining when a purchase of insurance by an employer establishes a "plan". Indeed, there is much confusion and conflict on this question. For example, in *Rizzi v. Blue Cross of So. California*, 206 Cal. App. 3d 380, 253 Cal. Rptr. 541 (1988), *cert. denied*, 110 S. Ct. 78 (1989) the California Court of Appeals stated:

> "We note that although the department of Labor regulation states an ERISA plan does not exist if, inter alia, no contributions are made by the employer, it does not necessarily follow that if an employer does make contributions, a plan automatically exists. In 29 Code of Federal Regulations section 2510.3-1(a)(4), the Department of Labor qualifies its regulation by stating, '[s]ome of the practices listed in this section as excluded from the definition of 'welfare plan' as mentioned as examples of general categories of excluded practices are inserted in response to questions received by the Department of Labor and, in the Department's judgment, do not represent borderline cases under the definition in section 3(1) [§1002, subd. (1)] of the Act. *Therefore, this section should not be read as implicitly indicating the Department's views on the possible scope of section 3(1).*' (Italics added)." 206 Cal. App. 3d at 388 n.8, 253 Cal. Rptr. at 546 n.8.

Where the employer was not actively involved in the administration of the plan, a California Appeals Court in *Sayble v. Blue Cross of Southern California*, 208 Cal. App. 3d 991, 256 Cal. Rptr. 820 (Cal. App. 1989) held that an employer-provided group health insurance plan was not governed by ERISA. In *Sayble*, the insured's employer paid premiums to a trust to obtain coverage for its employees under the Blue Cross plan, however, as in the case at bar, the employer had no express agreement with its employees to provide such coverage. The insured sued Blue Cross and an independent company hired by Blue Cross to provide administrative services in connection with the policy. The trial court entered summary judgment against the insured, ruling that ERISA preempted the insured's suit.

In reversing, the California appellate court concluded that the insured's employer had not established an "employee benefit plan" subject to ERISA's preemption provisions. The court concluded that the mere payment of premiums by an employer is not sufficient to give rise to an ERISA plan.

The court reasoned:

> "It is manifest that Swiss American did not administer the subject health program, and its role was essentially limited to paying the policy premiums. Again, the United States Supreme Court stated in *Fort Halifax Packing Co. v. Coyne, supra,* 482 U.S. at page 12: 'To do little more than write a check hardly constitutes the operation of a benefit plan. [Fn. omitted.]'
>
> Admittedly, *Fort Halifax* is distinguishable in that only a single set of severance payments was involved, while here, Swiss American regularly paid premiums over a period of years. However, Swiss American did not undertake administrative responsibilities 'such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements.' (*Id.*, at p. 9, 107 S. Ct. at p. 2216, 96 L. Ed. at p. 10.)
>
> Due to the lack of participation by Swiss American in the administration of the subject insurance benefit, the regulatory concerns of ERISA are not implicated." *Id.* at 825 (footnotes omitted).

In short, in this view, ERISA's regulatory concerns are not implicated when an employer merely makes premium payments to an insurance company without being

in a position to engage in self-dealing, make imprudent investments, or misappropriate funds.

A similar conclusion was reached by the Supreme Court of Nevada in *Turnbow v. Pacific Mutual Life Insurance Company*, 765 P.2d 1160 (Nev. 1988), *cert. denied*, 109 S. Ct. 2458 (1989) but on different reasoning. *Turnbow* involved an employer who purchased a health insurance policy for herself and her employees through a multiple employer trust. After the plaintiff suffered a stroke, the insurer paid her claim for policy benefits. However, the insurer raised her premiums until she could no longer make the payments and she lost her benefits. Plaintiff sued the insurer for breach of contract, insurance bad faith, violation of NRS 686A.010, infliction of emotional distress, and punitive damages. The trial court granted the insurer's motion to dismiss on the ground that plaintiff's sole remedy was under ERISA. In reversing, the Nevada Supreme Court ruled that no ERISA employee benefit plan was created:

> "ERISA does not regulate the bare purchases of health insurance where, as here, there is 'no indication' that the employer intended to guarantee the continued furnishing of the benefits." *Id.* at 1161.

In the case at bar, the insurer failed to produce any contract between the employees and the employer obligating the employer to purchase life insurance.

Mary Jane respectfully submits that before an insurer may invoke the shield of ERISA to preempt state law remedies it must prove not only that it sold a group policy to an employer but also that it has at least attempted to comply with applicable ERISA regulations.

## II. By Creating A Middle Ground Between Suicide And Accident, The First Circuit In *Wickman* Is In Conflict With The Better Reasoned State Cases.

According to the American Council of Life Insurance, 1988 Life Insurance Fact Book at 32, 69,394,000 people are insured by group life insurance policies paid for by the employer. The 1988 Life Insurance Fact Book at 44 indicates that $275 million dollars of accidental death payments were made during 1987. There are no statistics available on how many dollars worth of accidental benefit claims are made but denied by the insurer, but it is clear that the First Circuit's ruling on the standard for proving accidental death in ERISA covered policies will affect many millions of insurance dollars that will not be paid to beneficiaries under the newly created federal common law than would have been made under the law of the individual states, thereby providing the insurance companies with a windfall of unknown dimensions.

### A. The Creation of a Never-Never-Land Between Suicide and Accident Into Which the First Circuit Placed Mary Jane's Claim Results in an Unworkable Rule

The United States Supreme Court in the landmark case of *Landress v. Phoenix Mutual Life Ins. Co.*, 291 U.S. 491 (1934) applied a means/result distinction and determined that a man who died of heat stroke while golfing had not died of accidental means. The Court reasoned that because the insured had intentionally played golf and exposed himself to the hot sun for a long period of time, the means of his death, overexposure to the sun,

was not accidental.[4] Justice Cardozo dissented, arguing that the distinction was artificial and unworkable and warned that adherence to the distinction would "plunge this branch of the law into a Serbonian Bog." *Id.* at 499. The First Circuit recognized that "Time has borne out Cardozo's prediction" and acknowledged that "[I]n recent years courts consistently have rejected the distinction between accidental means and accidental results." (Appendix A, 18a, 19a). Unfortunately, the First Circuit then turned to three Russian roulette cases (Appendix A, 22a) from jurisdictions (Georgia, Tennessee, and West Virginia) which still follow the discredited accidental means/results distinction. Then the court formulated a "new" test which is no better nor more workable than the old one because it creates an unprecedented nether world between "accident" and "suicide," by placing reckless acts, which have traditionally been categorized as accidents (see citations *infra* at 27-29) into the category of non-accident. (See Appendix A at 25a n.5).

Yell, Northwestern's Supervisor, testified at trial that her review of the file indicated that this case "was going to come down to being either an accident or suicide." (3 Tr. 15). The December 12, 1985 denial letter specifically stated:

> "Because the Accidental Death provision of the policy excludes payment of benefits for suicide, we do not believe Accidental Death Benefits are payable." (E. 97).

Hence, even Northwestern recognized that there were only two possibilities: either accident or suicide.

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[4] *Landress* preceded *Erie v. Tompkins Railroad*, 304 U.S. 64 (1938), and, thus, is no longer binding as federal common law.

The creation of a third category "non-accident" for deaths related to an insured's reckless behavior will plunge ERISA into a "Serbonian Bog".

As noted above, despite the First Circuit's repudiation of the accidental means/accidental result distinction, the primary cases it relied on in denying Mary Jane's claim are discredited "accidental means" cases. See e.g. *Nicholas v. Provident Life & Acc. Ins. Co.*, 457 S.W.2d 536, 540 (Tenn. Ct. App. 1970) (First Circuit's Opinion Appendix A at 22a) ("The determinative question which confronts us here is whether or not there is any material evidence in the case from which reasonable persons could conclude that the decedent's death resulted from 'accidental means' as used in the insuring clause of the policy in question."); *Koger v. Mutual Omaha Ins. Co.*, 163 S.E.2d 672, 675 (W. Va. 1968) (First Circuit Decision, Appendix A at 22a) " . . . we think the plaintiff failed to establish that the insured's death was effected by accidental means within the meaning of that term in the policies of insurance . . . "); *Thompson v. Prudential Ins. Co.*, 66 S.E.2d 119, 124 (Ga. App. 1951) (First Circuit Decision at 22a) ("We think the plaintiff failed to establish that the insured's death was effected by accidental means within the meaning of that term in the policies"); and *Allred v. Prudential Ins. Co.*, 100 S.E.2d 226, 227, 230 (N.C. 1957) (First Circuit Decision Appendix A at 23a) (relying on accidental means cases and citing *Thompson* as approving and applying "accidental means" as referring to the occurrence or happening which produced the result, rather than the result. *Id.* at 230). Indeed, under a non-accidental means analysis there would have been recovery in *Allred* as the

14-year-old stated to his friends that he laid down lengthwise on the white center line of the highway to "show you all how brave I am." *Id.* at 228.

Moreover, the First Circuit's reliance on *Kennedy v. Washington National Ins. Co.*, 401 N.W.2d 842, 846 (Wis. Ct. App. 1987) (First Circuit opinion Appendix A at 23a) is misplaced because in *Kennedy* the beneficiary recovered and the next line of the quotation is "However, the intentional or unnecessary exposure to risks, as well as the negligent creation of risks to one's own safety, does not prevent the result from being accidental." *Id.*). Similarly, the First Circuit's reliance on *Hoffman v. Life Ins. Co.*, 669 P.2d 410, 419 (Utah 1983) (First Circuit Opinion Appendix A at 23a) is misplaced because the court also stated "Many cases have held that the term 'accident' in liability insurance contracts includes results recklessly caused by the insured." *Id.* at 417, n.3. Likewise, the beneficiary recovered in *New York Life Ins. Co. v. Harrington*, 299 F.2d 803 (9th Cir. 1962) (First Circuit Decision at 24a), and *Ward v. Penn Mutual Life Ins. Co.*, 352 S.W.2d 413, 423 (Mo. Ct. App. 1961) (First Circuit Decision Appendix A at 24a) and the remainder of the cases relied on by the First Circuit. (Appendix A pp. 23a-24a). Indeed, no recklessness case in which the beneficiary is denied benefits is ever cited by the First Circuit other than the "accidental means" cases distinguished above (all of which, except *Allred*, involved Russian Roulette).

Hence, the unprecedented decision of the First Circuit will plunge accidental death litigation under ERISA into a "Serbonian Bog."

**B. In Adjudicating Accidental Death Claims the Federal Common Law Under ERISA Should Follow the Majority of States in (A) Adopting the Presumption Against Suicide and (B) According to Death Certificates *Prima Facie* Evidence of the Facts Recorded.**

The First Circuit's decision states:

> "Because the magistrate decided there was no accident in this case, and we affirm on this basis, he did not and we need not reach the question of whether Wickman's death was actually a suicide. The failure to reach this issue makes the presumption relating to the death certificate and the presumption against suicide, relied upon extensively by the plaintiff, irrelevant." (See Appendix A at 25a n.5).

The First Circuit's error in failing to recognize that this claim involved either suicide or accident was discussed *supra* at 19. In determining whether death is accidental, the federal common law should accord to death certificates the *prima facie* evidence of the facts recorded and should adopt the presumption against suicide.

1. The Federal Rules of Evidence specifically defer to state law on presumptions. See F.R.E. Rule 302; *Pollard v. Metropolitan Life Insurance Co.*, 598 F.2d 1284, 1286 (3d Cir. 1979), cert. denied 100 S. Ct. 232, 444 U.S. 917 (1980). Although Rule 302 refers to "a presumption respecting a fact which is an element of a claim or defense as to which state law supplies the rule of decision" the Advisory Committee note to this rule observes that it is not limited to "diversity cases" and that it has been specifically applied to the burden of proof involving the "non-accidental death (suicide) of an insured." Following the rule

that " . . . it is proper . . . to look to state law in fashioning a federal common law rule, as long as the state law is consistent with the purposes underlying ERISA" *Tesch v. General Motors Corp.*, 724 F. Supp. 1251, 1253 (E.D. Wis. 1989), the *Tesch* court looked to a Wisconsin statute to determine the validity of a change in beneficiary on a life policy. It seems but a short, logical step to look to the applicable state statute governing the legal significance of death certificates.

M.G.L. c. 46, § 19 provides in pertinent part:

> "The record of the town clerk relative to birth, marriage or death shall be *prima facie* evidence of the facts recorded, but nothing contained in the record of a death which has reference to the question of liability for causing the death shall be admissible in evidence."

Massachusetts law creates a presumption that a death certificate is *prima facie* evidence of the facts reported. Accordingly, a death certificate determines a verdict if there is no controverted evidence provided. See *Shamlian v. Equitable Acc. Co.*, 115 N.E. 46 (Mass. 1917). The statutory language "evidence of the fact recorded" has been interpreted to include the coroner's opinion as to the cause of death. *Id.* at 48. *Accord Lydon v. Boston Elevated Ry.*, 34 N.E.2d 642, 647 (Mass. 1941) ("In the certificate of death under the heading, 'Disease or Causes of Death (Primary or Secondary)' the following appears: . . . unless there is other evidence to control, the facts therein stated must be taken as true.")

Thus, the corrected death certificate's statement in the instant case as "cause of death" to be "Massive internal hemorrhage secondary to fracture – dislocation of

pelvis – caused by 90 foot fall from bridge" (E. 7; P. Ex. 4) is *prima facie* evidence that death occurred by accident since no reasonable interpretation of this language permits an inference that death was occasioned by natural causes and, as discussed below, there is a presumption against death by suicide.

2. In Massachusetts, and generally elsewhere, there is a presumption against death caused by suicide. See, e.g., *Nicholas v. Commercial Travelers Eastern Accident Assoc.*, 109 N.E. 449, 451 (Mass. 1915) (insured fell out of window of pullman sleeping car, court held that there was a presumption that the death resulted from an accident); *Silva v. The Fidelity & Casualty Co.*, 147 N.E. 858, 859 (Mass. 1925) (drowning; "[v]oluntary self-destruction is contrary to the common conduct of mankind. It is a crime involving a high degree of moral turpitude. It is not assumed without clear proof"), *Eastern Commercial Travelers Acc. Ass'n v. Sanders*, 108 F.2d 643, 645 (1st Cir. 1940) (drowning; " 'The presumption is that one does not commit suicide.' This presumption has a logical foundation derived from human experience"), and *Bohaker v. Travelers Inc. Co.*, 102 N.E. 342, 344 (Mass. 1913) (fall out of window through covered screen; "The presumption is that one does not commit suicide").

Outside Massachusetts see, e.g., *Dick v. New York Life Insurance Co.*, 359 U.S. 437, 444, 79 S. Ct. 921, 925 (1959) (experienced hunter shot *twice* by shotgun; "Under [North Dakota] law . . . a presumption arises that death was accidental"),[5] and *Shtevelan v. Metropolitan Life Ins.*

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[5] In sustaining the jury verdict for the beneficiary the Supreme Court noted that, as with the evidence presented in

(Continued on following page)

*Co.*, 295 N.Y.S. 735 (1937), aff'd without opinion, 7 N.Y.S.2d 767 (App. Div. 1938) in which there were no witnesses to the insured's forty foot fall from his hospital room which occurred two days after he was diagnosed as having incurable cancer. (The court ruled that in the absence of any evidence showing that insured had a motive for suicide the plaintiff had *prima facie* case for death by accident). Also see *Canada Life Assurance Corp. v. Houston*, 241 F.2d 523, 531-532 (9th Cir. 1957) (self inflicted gunshot wound – presumption against suicide not overcome) and *Dortch v. New York Life Insurance Company*, 268 F.2d 149, 155 (9th Cir. 1959) (same).

The presumption against suicide and the *prima facie* effect of the corrected death certificate meant that as soon as Mary Jane read Northwestern's responses to her request for admissions and offered the relevant exhibits (1 Tr. 2-6 and E. 1-18; P. Exs. 1-7) she had presented the *prima facie* case for accidental death benefits and the burden was on Northwestern to prove suicide, i.e. that Paul intended to take his own life by jumping from the bridge, *not* that he had placed himself in a position of danger. See *Dick*, 359 U.S. at 443, 79 S. Ct. at 925 ("Proof of coverage and of death by gunshot wound shifts the

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(Continued from previous page)

the instant case, "The record indisputably shows a lack of motive – in fact there is affirmative evidence from which the jury could infer that *Dick* was a most unlikely suicide prospect. He was relatively healthy, financially secure, happily married, well liked, and apparently emotionally stable. He left nothing behind to indicate that he had committed suicide and nothing in his conduct before death indicated an intention to destroy himself." 359 U.S. at 446, 79 S. Ct. at 927.

burden to the insurer to establish that the death of the insured was due to his suicide"). Many persons place themselves in a position of danger and occasionally some lose their lives as a result. They have not committed suicide unless they intended to take their own lives; otherwise death in these circumstances is accidental.

### C. The First Circuit's Test for Accidental Death Eliminates a Number of Claims Which the Insurance Industry Contemplated Paying and Thereby Results in a Windfall to the Insurance Industry.

In sharp contrast to the First Circuit's decision in *Wickman*, the majority rule is that accidental death benefits are payable even if the insured intentionally placed himself in a position of danger or otherwise engages in careless, negligent, or reckless conduct. It is only where the insurer proves by a preponderance of the evidence that the insured not merely intended to inflict serious bodily injury or place himself in a position of danger, but actually intended to kill himself, that the insurer is entitled to deny benefits based upon the suicide exclusion. See e.g.:

1. "For the purposes of this suit, it is enough to say, that the policy was rendered void, if the insured was conscious of the physical nature of his act, and *intended* by it to cause his death . . . " *Bigelow v. Berkshire Life Ins. Co.*, 93 U.S. 284, 287 (1876) (emphasis added).

2. "The question is not whether death was reasonably foreseeable, but whether the death was in fact foreseen by the insured. In order to defeat recovery under a

double indemnity provision, as involved herein, the insured must have intended or expected that his conduct would in all probability result in his death. Negligence alone is not sufficient to prevent the death from being an accident within the meaning of the policy." *Collins v. Nationwide Life Ins. Co.*, 294 N.W.2d 194 (Mich. 1980) (Michigan Supreme Court reversed trial court finding in favor of defendant where death was caused by acute alcoholic intoxication.)

3. "We therefore hold that where an insured dies as a result of an intentional or expected act or event, but did not intend or expect death to result, the death is 'accidental' within the contemplation of that term, as utilized in a policy such as the one before us. See *Knight v. Metropolitan Life Insurance Company*, 437 P.2d 416, 420 (Ariz. 1968)]; *Miller v. Continental Ins. Co.*, 40 N.Y.2d 675, 389 N.Y.S.2d 565, 358 N.E. 258 (1976)." *Catania v. State Farm Life Ins. Co.*, 598 P.2d 631, 633 (Nev. 1979) (summary judgment for insurer reversed where death occurred through self-administered heroin injection even though the amount of the dosage was "well in excess of the amount [the insured] was in the habit of ingesting", 598 P.2d at 635.)

4. "Plaintiff makes a case, the other elements of her cause of action having been established, if the *injury* [death], as distinguished from the means by which the injury [death] was accomplished, was accidental. The distinction is that between cause and effect. Although Thelma Kearbey may have intentionally consumed the fatal combination, the *injury* [death], that is the effect, was accidental if it was not intended." *Kearbey v. Rel. L. Ins. Co. of Webster Groves*, 526 S.W.2d 866, 873 (Mo. App.

1975) (emphasis by the court) (death due to overdose of alcohol and butabarbital).

5. "In the instant case, Rodgers consciously incurred a known hazard in attempting to negotiate the curve in the highway at the high rate of speed he was travelling. He clearly failed to exercise judgment, which was careless, reckless, perhaps foolhardy, but it does not follow that he intended to destroy himself or imperil the lives of his guest passengers." *Rodgers v. Reserve Life Insurance Company*, 132 N.E.2d 692 (Ill. App. 1956) (judgment for defendant reversed where insured died after failing to negotiate a curve driving at 100 mph when car hit steel guard rail, turned over on its top, and skidded another 50 feet).

6. "Thus, despite the fact that the means of destruction in the instant case, the act of self-injection, was intentionally caused by the decedent, the mishap must be regarded as an accident since the result of an intentional act, the death, was unintended." *Marsh v. Metropolitan Life Ins. Co., Inc.*, 388 N.E.2d 1121, 1127 (Ill. App. 1979) (judgment on verdict in favor of insurer reversed where appellate court ruled as a matter of law that death of plaintiff's decedent from self-administered overdose of heroin was accident).

7. "The courts, however, which have been concerned only with interpreting and applying the term 'accident' have, with substantial uniformity, reached the conclusion that if death results from the voluntary act of the victim, but the result is unexpected, unanticipated, and unforeseen, it is an accidental death." *Menton v.*

*Stuyvesant Life Ins. Co.*, 373 F. Supp. 33, 35 (D. Nev. 1974) (death by acute alcoholic ingestion held to be accident).

Accord: *O'Toole v. New York Life Ins. Co.*, 671 F.2d 913, 914 (5th Cir. 1982 applying Louisiana law) (death due to self-administered injection of cocaine was accidental); *Sevely v. American National Insurance Company*, 454 S.W.2d 799 (Tex. App. 1970) (directed verdict for insurer reversed where death resulted from head-on collision while insured was proceeding the wrong way on a divided highway; "The mere fact that the deceased was intentionally doing an act out of which the collision occurred does not make the collision non-accidental", *Id.* at 801), *Russell v. Metropolitan Life Ins. Co.*, 439 N.E.2d 89 (Ill. App. 1982) (judgment for a beneficiary affirmed where death was due to consumption of lethal quantity of alcohol, *Id.* at 90), *Pacific Mut. Life Ins. Co. v. Yeldell*, 62 So.2d 805 (Ala. App. 1953) (recovery of accidental benefits affirmed where death was due to fall from restroom window on twelfth floor of office building in which decedent worked), and *Pilot Life Ins. Co. v. Ayers*, 163 F.2d 860, 864 (4th Cir. 1947) (recovery where death resulted from fall from window of a hotel where insured was intoxicated).

Mary Jane respectfully submits that this Court ought to grant her Petition for Certiorari in order to follow the reasoning in these cases and hold that even if an insured intentionally places himself in a position of danger, accidental death benefits are payable unless the insurer demonstrates that the insured intended to take his own life. A contrary approach will plunge the federal common law into a "Serbonian Bog" and result in distinctions which, as the First Circuit has stated "courts consistently have rejected." (Appendix A at 19a).

## CONCLUSION

For these reasons, Petitioner requests this Court to issue a writ of certiorari to the United States Court of Appeals for the First Circuit.

Respectfully submitted,

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MARY JANE WICKMAN,

**Plaintiff, Appellant,**

**v.**

NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY,

**Defendant, Appellee.**

**No. 89-2030.**

United States Court of Appeals,
First Circuit.

Heard May 9, 1990.

Decided July 20, 1990.

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Richard L. Neumeier with whom Parker, Coulter, Daley & White, Boston, Mass., was on brief, for plaintiff, appellant.

Edward S. Rooney, Jr., with whom Lyne, Woodworth & Evarts, Boston, Mass., was on brief, for defendant, appellee.

Before SELYA and CYR, Circuit Judges, and ROSENN,* Senior Circuit Judge.

ROSENN, Circuit Judge.

This appeal calls upon us to examine the emerging jurisprudence of the Employee Retirement Income Security Act (ERISA) (29 U.S.C. § 1001 et seq.), and presents a question of first impression under the Act concerning the interpretation of life insurance contracts. The issue arises

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*Of the Third Circuit, sitting by designation.

out of the beneficiary's claim for accidental death and dismemberment benefits (AD&D) under a group policy issued by Northwestern National Life Insurance Company (Northwestern) insuring her husband, Paul Wickman (Wickman). Northwestern rejected the spouse's claim, asserting that Wickman's death, which resulted when he fell forty to fifty feet from a bridge, was not accidental.

The widow sued Northwestern in the United States District Court for the District of Massachusetts to recover AD&D benefits.[1] By consent of the parties, a magistrate tried the case and ruled that Wickman's death was not accidental. On appeal, the widow challenges this conclusion, as well as the earlier ruling that ERISA and not state law governed the insurance contract. We affirm.

I.

A.

On July 11, 1984, at approximately 4:00 P.M. Michael Blanchette was driving southbound on Route 495 in Middleborough, Massachusetts. As he approached the bridge near the overpass of Route 105 he observed an automobile, later identified as Wickman's, parked in a breakdown, lane, and Wickman approximately thirty feet away. He saw Wickman standing on the outside of the bridge's

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[1] The district court initially exercised jurisdiction pursuant to 28 U.S.C. § 1332(a). Upon the dismissal of the common law claims and the addition of the ERISA claims, the district court's jurisdiction was grounded in 29 U.S.C. § 1001 and 28 U.S.C. § 1331. This court has jurisdiction pursuant to 28 U.S.C. § 1291.

guardrail, holding on to it with only his right hand. Blanchette turned his eyes to check on traffic, and upon looking back he saw Wickman no longer holding on to the rail but free-falling to the railroad tracks below.

At the point from which Wickman had been first observed, the bridge had been erected forty to fifty feet above the railroad tracks below. About thirty-five yards further on, the bridge stands ninety feet above the tracks. To reach that point, Wickman would have had to walk head on into high speed traffic.

The bridge guardrail is three to four feet high and is constructed of intermittent vertical concrete posts crossed by three continuous metal horizontal railings. No area or lip extends outside the railing on the bridge for walking or standing. An edge of a steel support beam about one foot below the bridge roadway projects outward for a few inches. The magistrate ultimately concluded, "It is not reasonable to believe that Mr. Wickman either fell over or through the guardrail, or otherwise came to be on the outside through mistake or inadvertence. Clearly it would take a conscious effort to climb over or through the guardrail on the bridge."

Upon seeing Wickman fall, Blanchette pulled over, stopped a tow truck and requested the driver to obtain police and ambulance assistance. Blanchette then ran down the embankment to administer first aid to Wickman. Blanchette treated him for shock and asked him several questions. Wickman told Blanchette his name, occupation, and that he had a family. Blanchette asked Wickman in "two or three different ways" why he had jumped, but Wickman failed to respond.

Blanchette eventually left Wickman and flagged down Trooper Condon, who called for an ambulance and then attended to Wickman. Condon also asked Wickman some general questions, and obtained responses to all of his questions except as to what had happened. Shortly thereafter an ambulance arrived and transported Wickman to St. Luke's Hospital.

Upon admission, Trudy Dooley, the hospital emergency admissions secretary, asked Wickman the standard admissions questions, including who were his next of kin. Though Wickman responded to questions such as name and address, he would not provide at first the next of kin information. Eventually after some prodding, he told Dooley that "they don't care," and "it doesn't matter." When asked about his religion, his initial response also was "it doesn't matter." When Dooley asked what had happened, he told her "I jumped off."

Mrs. Wickman soon arrived at St. Luke's, but by the time she got there Wickman had been heavily medicated. She spoke with him, touched and kissed him, but evidently he did not recognize her for he kept saying, "Where's my wife?" and "I love my wife and I love my children." Soon after, Wickman went into cardiac arrest and was transferred to Brockton Hospital where he died later that evening.

At the Brockton Hospital, Dr. Howard Carpenter, a medical examiner, who had been advised that Wickman had jumped, issued the initial death certificate. He stated the cause of death as suicide. Shortly thereafter, a nurse's note from St. Luke's was brought to Carpenter's attention. The note read, "admission to E.R. post-fall from 50'

bridge to rail track, awake oriented X 3, states 'fell.'" Exhibit P8. As Dr. Carpenter explained, oriented times three means oriented to person, place, thing, and time; "[h]e knows who he is, where he is, and what time it is, what day it is." On the basis of this note and no other information, Dr. Carpenter issued an amended certificate, fixing the cause of death as "fall from 90 foot bridge." Dr. Carpenter claims that this is the only death certificate he ever changed in the more than five thousand which he had prepared during his time in the coroner's office.

B.

At the time of his death, Wickman was covered by a Northwestern issued group life and AD&D policy held by his employer, Dexter Corporation (Dexter). The policy named his wife as the beneficiary; it provided for payment of life insurance benefits for all causes of death and AD&D benefits if death was accidental. The accidental death provisions provided that an accident was "an unexpected, external, violent and sudden event." The policy also specifically noted that it did not pay benefits if the loss was either directly or indirectly caused by "suicide or intentionally self-inflicted injury, whether . . . sane or insane."

The employer Dexter and the employees paid the premiums on the policy to Northwestern. Wickman became eligible for the insurance as a member of the class of Dexter "active full time employees regularly working 32 hours or more per week in a permanent position." As the party ultimately responsible for premium payments, Dexter held title to the policies.

Mrs. Wickman submitted claims to Northwestern under both the accidental death and life insurance policy provisions. She received a benefit payment of $105,000 on the life insurance policy. Following its investigation, Northwestern denied her claim for an equal amount under the accidental death provisions. The Company wrote to claimant's counsel:

> The policy defines accident as an unexpected, external, violent and sudden event. It further provides that we do not pay benefits for loss directly or indirectly caused by suicide or intentionally inflicted injury whether sane or insane.
>
> According to the police report the Insured's wife stated that her husband had been seeing a psychiatrist and had talked about suicide. The Death Certificate also indicates that the cause of death was suicide. Because the Accidental Death provision of the policy excludes payment of benefits for suicide, we do not believe Accidental Death Benefits are payable.

Exhibit D1.

In her suit, the spouse asserted a claim for breach of contract and requested a jury trial. She alleged that Wickman had not committed suicide, but ended up on the wrong side of the guardrail when he became disoriented while looking for help after his car broke down. His car had been retrieved by his daughter from the police the day after his death. She drove the car away without any difficulty, and a subsequent mechanical inspection found no defect. The widow also asserted that her husband, a devout Catholic, would not commit suicide, and that he was in the midst of planning a vacation. Finally, she

alleged that he showed no signs of depression, and had never contemplated suicide.

The district court, upon Northwestern's motion, dismissed the complaint, holding that the insurance policy was a part of the plan governed by ERISA, and as such ERISA preempted any state law claims. The court allowed plaintiff leave to amend, and she amended the complaint to add claims under ERISA. The court, in reliance upon its earlier decision, summarily dismissed the common law claim. The parties agreed that there was no right to a jury trial in an action for benefits brought under ERISA and consented to a trial before a United States Magistrate.

After a full trial, the magistrate performed a de novo review of the facts and determined that Wickman's death was not accidental. He denied the widow's claim for AD&D benefits. He found that Wickman had intentionally climbed over the guardrail, and that in so doing he was "substantially certain" that he would suffer significant injuries, if not death. Specifically, "the court [found] that Mr. Wickman knew or should have known that serious bodily injury or death was a probable consequence substantially likely to occur as a result of his volitional act of placing himself outside of the guardrail and hanging on with one hand." *Id.* at 67-68. The court held as a matter of law that the insured did not lose his life because of an accident as defined under the policy. His widow now appeals this ruling and, in the alternative, challenges the magistrate's prior ruling that ERISA preempted her common law claim.

II.

The threshold question in this case is whether plaintiff's claim is properly a claim under ERISA, or, in the alternative, a claim under state law. 29 U.S.C. § 1003(a) provides that ERISA supersedes any and all state law, except for state insurance, banking, and securities regulation. Under this section, a claimant's common law contract and torts claims asserting the improper processing of a claim for benefits under an ERISA regulated insurance policy are pre-empted. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57, 107 S.Ct. 1549, 1558, 95 L.Ed.2d 39 (1987). Insurance coverage which is part of an ERISA plan is regulated under ERISA. *See id.* at 48, 107 S.Ct. at 1553. The magistrate, finding that the AD&D policy at issue here was part of an ERISA plan, held that the widow's claims were limited to those under ERISA. *See Metropolitan Life Ins. Co. Taylor*, 481 U.S. 58, 62-63, 107 S.Ct. 1542, 1546, 95 L.Ed.2d 55 (1987).

> ERISA applies to:
>
> any employee benefit plan if it is established or maintained –
>
> (1) by any employer engaged in commerce or actively affecting commerce; or
>
> (2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or
>
> (3) both.

29 U.S.C. § 1003(a). The question of whether an ERISA plan exists is "a question of fact, to be answered in light of all the surrounding facts and circumstances from the

point of view of a reasonable person." *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988), *cert. denied*, ___ U.S. ___, 109 S.Ct. 3216, 106 L.Ed.2d 566 (1989).

In a cursory fashion, the statute defines an employee benefit plan as "an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan." 29 U.S.C. § 1002(3). As one court has noted, a welfare benefit plan under ERISA requires five essential constituents:

> (1) a plan, fund or program (2) established or maintained (3) by an employer or by an employee organization, or by both (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to participants or their beneficiaries.

*Donovan v. Dillingham*, 688 F.2d 1367, 1370 (11th Cir. 1982) (en banc). There is no dispute that the last three prerequisites were met in this case. The real dispute is whether this is a plan which the employer "established or maintained."

The court in *Donovan* also formulated the prevailing standard for determining whether a plan has been established.

> In summary, a "plan, fund or program" under ERISA is established if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries,

> the source of financing, and procedures for receiving benefits.

*Id.* at 1373. As the magistrate points out, this test is easily met in this case and the plaintiff-widow never contests that the intended benefits were accident insurance benefits. The beneficiaries were full-time employees and their appointed beneficiaries. Dexter, the employer, financed the plan and possibly also employee contributions. Dexter fixed a formal claim procedure, which the widow in fact used. The plaintiff contends, though, that to be a plan there must be something more: the mere purchase of insurance is not enough to constitute a plan. *See Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208, 1211 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030, 101 S.Ct. 1739, 68 L.Ed.2d 225 (1981).

The plaintiff's basic assertion that a mere purchase of insurance does not constitute a plan is correct, though in this case there is more than a mere purchase of insurance. In *Taggart*, relied upon by the widow, the employer acted solely as a channel for payments from the employee to a trust fund which purchased the group insurance. The employer "neither directly nor indirectly own[ed], control[led], administer[ed], or assume[d] responsibility for the policy or its benefits." *Id.* All it did was deduct funds from the employee's pay check, and transfer the funds to the trust fund. Significantly, there was only one employee covered under that insurance, the employer's only employee.

*Taggart*, thus, does not stand for the proposition "that an employer or employee organization that only purchase a group health insurance policy or subscribes to a [multiple employer trust] to provide health insurance to its

employees or members cannot be said to have established or maintained an employee welfare benefit plan." *Donovan*, 688 F.2d at 1375. In fact, "the purchase of a group policy or multiple policies covering a class of employees offers substantial evidence that a plan, fund, or program has been established." *Id.* at 1373. *Taggart* is merely a recognition that ERISA is not intended to cover situations where the employer merely "advertises" insurance, and then makes voluntary deductions from employees' paychecks. *See* 29 C.F.R. § 2510.3-1(j).

The crucial factor in determining if a "plan" has been established is whether the purchase of the insurance policy constituted an expressed intention by the employer to provide benefits on a regular and long term basis. *See Ed Miniat, Inc. v. Globe Life Ins. Group*, 805 F.2d 732, 739-41 (7th Cir. 1986), *cert. denied*, 482 U.S. 915, 107 S.Ct. 3188, 96 L.Ed.2d 676 (1987). For example, in *Donovan* the court paid particular attention to the written agreement that the employers had to either provide benefits or "purchase benefits for a substantial percentage of a class of employees or members under circumstances tending to show an anticipated continuing furnishing of such benefits." *Donovan*, 688 F.2d at 1374-75. Significantly, there were no indicia of a long term commitment in *Taggart*, where it appears the benefits, what little they amounted to, had no sense of permanence. *See Taggart*, 617 F.2d 1211.

In this case, the purchase of the insurance was not an isolated and aberrational incident, limited only to accident insurance, or simply to Wickman. Dexter provided a comprehensive insurance program, offering health, medical, dental, and life insurance, as well as several other

forms of insurance and benefits. Exhibit P17. It distributed a handbook containing a listing of ERISA rights and a summary plan description. Such a booklet, detailing ERISA rights, is strong evidence that the employer has adopted an ERISA regulated plan. *See Kanne*, 867 F.2d at 493. The Company here also contemplated and devised specific insurance eligibility requirements. Apparent from this degree of planning, precision, and detail is that the purchase of the group policy was not an aberrational or singular act, but represented Dexter's calculated commitment to qualified employees for similar benefits regularly in the future. Thus, the group accident insurance formed a considered employer plan under ERISA, making the plaintiff's claims under the policy subject exclusively to ERISA's jurisdictional requirements.

III.

Having crossed the ERISA threshold, we must now determine whether the magistrate correctly ruled that Wickman's death was not the result of an accident, and whether he properly denied the widow's claim for accidental death benefits. The magistrate found that there were only three possible explanations for Wickman's actions: Wickman intentionally projected himself over a dangerous visible void intending to (1) commit suicide, (2) seriously injure himself, or (3) having so positioned himself, fell inadvertently or mistakenly. The magistrate ruled that under the first two scenarios the policy exclusion of losses resulting from suicidé or intentionally self-inflicted injury controlled and mandated denial of the claim. Assuming arguendo the third scenario, an inadvertent or mistaken fall, he held that even if Wickman had

no specific intent to injure or kill himself, "the harm that befell him was substantially certain to happen." Once Wickman intentionally climbed over the guardrail and suspended himself with one hand, the magistrate found that serious bodily injury was substantially certain. This, he found, is not a case where the insured "intentionally did an act with some unexpected result." He therefore concluded as a matter of law that the insured did not lose his life due to an accident as defined under the policy or Massachusetts law. The widow challenges the legal conclusions drawn by the magistrate. She contends that under the second and third hypotheticals, Wickman died accidentally and, absent an explicit finding of suicide, she is entitled to the policy benefits.

A.

The benefit provisions of an ERISA regulated group life insurance program must be interpreted under principles of federal substantive law. *Pilot Life Ins.*, 481 U.S. at 56-57, 107 S.Ct. at 1557-58. *Burnham v. Guardian Life Ins., Co.*, 873 F.2d 486, 489 (1st Cir. 1989). The federal common law on the issue of insurance benefits is still in its formative stage but "must embody common-sense canons of contract interpretation." *Id.* Nonetheless, in developing the federal common law, it is not inappropriate that we examine the various state law approaches, states generally having had much more experience in the area of insurance contract interpretation. Borrowing those concepts which are best reasoned may be prudential.

Applying the basic tenets of contract interpretation, the first place to look for a definition is in the terms of the

policy contract itself. *Id.* These terms must be given their plain meanings, meanings which comport with the interpretations given by the average person. *See Hoffman v. Life Insurance Co.*, 669 P.2d 410, 416 (Utah 1983); *Knight v. Metropolitan Life Ins. Co.*, 437 P.2d 416 (Ariz. 1968); 10 *Couch on Insurance 2d*, § 41:9, 13 (1982). Courts have also held, nearly unanimously, "that insurance contracts must be liberally construed in favor of a policyholder or beneficiary . . . and strictly construed against the insurer in order to afford the protection which the insured was endeavoring to secure when he applied for the insurance." 13 Appleman, *Insurance Law and Practices* § 7401 at 197 (1976). *See Howard v. Federal Crop Ins. Corp.*, 540 F.2d 695 (4th Cir. 1976); *Rezendes v. Prudential Ins. Co.*, 285 Mass. 505, 189 N.E. 826 (1934).

The policy in this case specifically provides that benefits will not be paid "for loss directly or indirectly caused by . . . [s]uicide or intentionally self-inflicted injury, whether [insured is] sane or insane." We are bound by this plain language, and we may not distort it in an effort to achieve a desirable or sympathetic result. The language, in the clearest of terms, denies benefits if Wickman committed suicide, the magistrate's first scenario.

Similarly, if Wickman merely attempted to injure himself, and did not specifically intend to kill himself (scenario two), again no benefits would be due his widow. His death would have been "indirectly caused" by his attempt to injure himself. The plain language of the policy denies benefits under such a [sic] circumstances. To read the policy in any other way would be to

give no effect to the contractual clause "directly or indirectly caused by," a result inconsistent with the basic rules of contractual interpretation. Thus, the magistrate correctly ruled that under his first two scenarios, Northwestern would not be liable under the policy to the plaintiff for accidental death benefits.

This still leaves us with the more vexing questions raised under the magistrate's third scenario: whether the widow is due benefits if Wickman climbed over the guardrail without any intent to kill or injure himself but fell inadvertently. The resolution of this hypothesis requires that we delve into the metaphysical conundrum of what is an accident.

B.

In defining the term "accident," as in other terms used in an insurance contract, we, of course, first look at the contract. The language in this contract, though, is somewhat less than dispositive.[2] It defines "accident" as

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[2] The contract, in its relevant portion, reads:

What is the Accidental Death and Dismemberment (AD&D) Benefit:

We pay AD&D benefits if you lose your life, limb, or sight due to accidental injury.

Under what conditions do we pay benefits? We pay benefits if all of the following are true:

– You are covered by AD&D Insurance on the date of the accident.

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"an unexpected, external, violent, and sudden event." It is undisputed that the fall was external, violent, and sudden, but the parties disagree over whether it was unexpected. Northwestern contends that when Wickman climbed over the railing and extended himself from the bridge he must have expected that he would fall and kill or, at least, significantly injure himself. His widow contends that only if Wickman intended to commit suicide could the incident not be an accident; otherwise, he would not have expected to die. The question comes down to what level of expectation is necessary for an act to constitute an accident; whether an intentional act proximately resulting in injury or only the ultimate injury itself must be accidental.

A survey of state judicial interpretations of "accidental" reveals that there are essentially two approaches to determining whether an injury was "unexpected" and thus "accidental." In developing federal common law, it would be jurisprudential to analyze each of these approaches and determine which is the soundest and most consonant with the spirit of ERISA in promoting fair and equitable settlements of claims, as well as in promoting the formation of employee benefit plans. *See Pilot Life*, 481 U.S. at 54, 107 S.Ct. at 1556.

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- Loss occurs within 180 days of accident.

- The cause of the loss is not excluded.

It is evident from this clause that an injury must be accidental to qualify for AD&D Benefits. Thus, for the plaintiff to have made out a prima facie case, she had to establish that Wickman's death was an "accident" within the terms of the policy.

The First approach distinguishes between accidental means and accidental results. Under this approach, where the insurance contract insures against "accidental means," the means which produced death or injury must have been unintentional. According to this interpretation, if the act proximately leading to injury is intentional, then so is the result, even if the result itself was neither intended nor expected. To constitute an accident under this standard, the *cause* of the injury, as Couch explains, must be "unforeseen, unexpected, and unusual; happening or coming by chance without design, that is casual or fortuitous, as opposed to designed or intended." 10 Couch on Insurance 2d § 41:28, 40 (1982).

A court only will focus on "accidental means," though, if the language of the contract specifically speaks of accidental means. The contract in this case defines an accident in terms of an event. This would be the type of language which would prompt courts recognizing the distinction between "means" and "results" to look at the "means," because only the means can be termed an event. These courts would reason that if the contract had intended a "result" analysis, it would have spoken of an unexpected injury, not an unexpected event. Similarly, "violent, external, and sudden" terms concentrate upon the cause of the injury, not upon the injury itself.

The United States Supreme Court, in a landmark case, applied the means/result distinction and determined that a man who died of heat stroke while golfing had not died of accidental means. The Court reasoned that because the insured had intentionally played golf and exposed himself to the hot sun for a long period of time, the means of his death, overexposure to the sun,

was not accidental. *Landress v. Phoenix Mutual Life Ins. Co.*, 291 U.S. 491, 54 S.Ct. 461, 78 L.Ed. 934 (1934).[3] Justice Cardozo dissented, harshly criticizing the "artificial" distinction between accidental means and results. He noted that:

> "Probably it is true to say that in the strictest sense and dealing with the region of physical nature there is no such thing as an accident." Halsburg, L.C. in *Brintons v. Turvey*, L.R. [1905]. . . . On the other hand, the average man is convinced that there is, and so certainly is the man who takes out a policy of accident insurance. It is his reading of the policy that is to be accepted as our guide, with the help of the established rule that ambiguities and uncertainties are to be resolved against the company.
>
> * * *
>
> When a man has died in such a way that his death is spoken of as an accident, he has died because of an accident, and hence by accidental means.

*Id.* at 499 (citations omitted). Cardozo forewarned that adherence to the distinction would "plunge this branch of the law into a Serbonian Bog." *Id.*

Time has borne out Cardozo's prediction. As the Texas Supreme Court has noted:

> Texas courts have waded through Justice Cardozo's Serbonian bog, and we are now convinced that the terms "accidental death" and

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[3] *Landress* preceded *Erie Railroad Co. v. Tompkins*, 304 U.S. 64, 58 S.Ct. 817, 82 L.Ed. 1188 (1938), and, thus, is no longer binding as federal common law.

> "death by accidental means," as those terms are used in insurance policies, must be regarded as legally synonymous. . . .

*Republic National Life Insurance Company v. Heyward*, 536 S.W.2d 549 (Tex. 1976); *see also Beckham v. Travelers Ins. Co.*, 424 Pa. 107, 225 A.2d 532, 535 (1967) ("Our own cases have also confirmed Cardozo's prediction. . . . "). Other courts have been equally frustrated by the means/injury distinction, which has "shrouded [this branch of law] in a semantic and polemical maze," and forced courts applying the distinction to resort to "tortuous and tortured legal jiujitsu)." Annotation, *Insurance: "Accidental Means" as Distinguishable from "Accident," "Accidental Result," "Accidental Death." "Accidental Injury," etc.*, 166 A.L.R. 469, 477 (1947).

In recent years, courts consistently have rejected the distinction between accidental means and accidental results noting that:

> it is illogical to purport to distinguish between the accidental character of the result and the means which produce it; that the distinction gives to "accidental means" a technical definition which is not in harmony with the understanding of the common man; and that the ambiguity found in the concept should be resolved against the insurer so as to permit coverage.

10 *Couch on Insurance 2d* § 41:31, 50 (1982); *see also Page Flooring and Constr. Co. v. Nationwide Life Ins. Co.*, 840 F.2d 159, 162 (1st Cir. 1988) (Coffin, J., dissenting) (urging the interpretation prevailing in an increasing number of jurisdictions that the two terms be construed as synonymous and rejecting the distinction between "accidental means"

and "accidental results" as artificial and confusing). Having reviewed the pertinent state court decisions, we conclude that the better reasoning rejects the distinction. Thus, we elect to pursue a path for the federal common law which safely circumvents this "Serbonian Bog."

C.

This election, however, does not resolve the debate over what constitutes an accident nor does it resolve the case before us. In ultimately determining what is an accident, we are still left with questions concerning the standards by which to judge the insured's expectations. The plaintiff advances the argument that anything short of specifically intended injury is an accident. The magistrate, though, disagreed with this proposition and ruled that even if Wickman did not intend to kill or injure himself, he did not die accidentally. Despite the widow's contention, the magistrate did not apply an "intentional means" analysis in reaching this conclusion, but instead determined that Wickman either actually expected or reasonably should have expected the ultimate result which befell him. Because of this expectation – not merely because the means of death was voluntary – the magistrate held that Wickman's death was not accidental.

Defining accident has troubled the state and federal judiciaries for year. Probably the best definition is Cardozo's tautology that an accident is what the public calls an accident, which aids jurists in deciding individual cases only slightly. As the late Justice Musmanno of the Pennsylvania Supreme Court bemused:

> What is an accident? Everyone knows what an accident is until the word comes up in court. Then it becomes a mysterious phenomenon, and, in order to resolve the enigma, witnesses are summoned, experts testify, lawyers argue, treatises are consulted and even when a conclave of twelve world-knowledgeable individuals agree as to whether a certain set of facts made out an accident, the question may not yet be settled, and it must be reheard in an appellate court.

*Brenneman v. St. Paul Fire and Marine Ins. Co.*, 411 Pa. 409, 192 A.2d 745, 747 (1963); *see Burr v. Commercial Travelers Mut. Acc. Ass'n*, 295 N.Y. 294, 301, 67 N.E.2d 248, 166 A.L.R. 462, 466 (N.Y. 1946) ("Philosophers and lexicographers have attempted definition with results which have been productive of immediate criticism. No doubt the average man would find himself at a loss if asked to formulate a written definition. . . . "). Much of the inconsistency in the case law defining and applying the definition of accident is traceable to the difficulty in giving substance to a concept which is largely intuitive. Recognizing this problem, we continue our trek across this judicial morass realizing that some mud on our boots may be inevitable. Nonetheless, we continue to strive to avoid miring in a "Serbonian Bog."

Case law is fairly consistent in defining an accident, using equally ambiguous terms such as undesigned, unintentional, and unexpected. *See Beacon Textiles Corp. v. Employees Mut. Liab. Ins. Co.*, 355 Mass. 643, 246 N.E.2d 671, 673 (1969); 1A Appleman, *Insurance Law and Practice* § 360, 449 (1982). The contract at issue here uses the term "unexpected." These terms offer no guidance in determining from whose perspective they should be judged.

The common law has filled this gap, to a certain extent, by prescribing that these terms should be judged from the viewpoint of the insured. *See Id.* at 450-52; *Estate of Wade v. Continental Ins. Co.*, 514 F.2d 304, 306-07 (8th Cir. 1975).

The plaintiff would have us rule that this common law premise means that unless Wickman actually expected to die, essentially that he specifically intended to commit suicide, his death must be considered an accident. Such a strict definition from the perspective of the insured suffers from two imperfections, both of which make the test inappropriate in certain cases. The first difficulty comes in cases where an insured's expectations, virtually synonymous with specific intent, are patently unreasonable.

To illustrate, there are several reported cases of people who have participated in games of Russian roulette[4] not expecting or intending that they be killed, evidently entertaining a fanciful expectation that fate would inevitably favor them. The courts have generally held that the insureds' deaths in these cases, regardless of actual expectation or intention, were not accidental. *See Nicholas v. Provident Life & Acc. Ins. Co.*, 61 Tenn. App. 633, 457 S.W.2d 536 (1970); *Koger v. Mutual of Omaha Ins. Co.*, 152 W.Va. 274, 163 S.E.2d 672 (W.Va. 1968); *Thompson v. Prudential Ins. Co.*, 84 Ga. App. 214, 66 S.E.2d 119 (1951).

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[4] A game where the participants inject one bullet in one chamber of a pistol, spin the barrel, place the pistol to their heads, and pull the trigger. A player playing by the rules will not make any effort to check if the firing chamber is empty before pulling the trigger. Thus, essentially a participant relies solely upon fate to determine if he or she will be shot.

When a person plays a game like Russian roulette and is killed, the death, to use Cardozo's test, would not be publicly regarded as an accident. *See also Allred v. Prudential Ins. Co.*, 247 N.C. 105, 100 S.E.2d 226 (1957) (no accident where insured, a fifteen year old boy, intentionally laid down lengthwise in the middle [sic] a highway and was subsequently run over and killed). To allow recovery in such circumstances would "defeat the very purpose or underlying function of accidental life insurance." *Kennedy v. Washington National Ins. Co.*, 136 Wis.2d 425, 401 N.W.2d 842, 846 (Ct. App. 1967).

The second difficulty with a test relying upon actual expectation is that actual expectation is often difficult, if not impossible, to determine. As one court has noted, "the subjective state of the mind of the insured cannot be generally known." *Hoffman v. Life Ins. Co.*, 669 P.2d 410, 419 (Utah 1983). Generally, to make an "accident" solely dependent upon actual expectation compels courts and jurists to hypothesize and speculate. As in a case like this, where there are only vague clues as to what Paul Wickman actually thought when he climbed over the guardrail, efforts to recreate a person's actual expectations encounter the evident risks of error and frustration. It is an uncertain and too often a hopelessly blind search for the truth.

Notwithstanding these problems, we do not suggest actual expectation should be wholly ignored, for in most cases actual expectations govern the risks of an insurance policy a beneficiary believes has been purchased. Generally, insureds purchase accident insurance for the very purpose of obtaining protection from their own miscalculations and misjudgments. *See Knight v. Metropolitan*

*Life*, 103 Ariz. 100, 437 P.2d 416 (1968); 1A Appleman, *supra* § 360, 454. Thus, the reasonable expectations of the insured when the policy was purchased is the proper starting point for a determination of whether an injury was accidental under its terms.

If the fact-finder determines that the insured did not expect an injury similar in type or kind to that suffered, the fact-finder must then examine whether the suppositions which underlay that expectation were reasonable. *See New York Life Ins. Co. v. Harrington*, 299 F.2d 803, 806 (9th Cir. 1962). This analysis will prevent unrealistic expectations from undermining the purpose of accident insurance. If the fact-finder determines that the suppositions were unreasonable, then the injuries shall be deemed not accidental. The determination of what suppositions are unreasonable should be made from the perspective of the insured, allowing the insured a great deal of latitude and taking into account the insured's personal characteristics and experiences. *See, e.g., Ward v. Penn Mutual Life Ins. Co.*, 352 S.W.2d 413, 423 (Mo. Ct. App. 1961) (finding accident where man fell off top of moving car; he had performed the stunt previously, knew, and trusted the driver, was strong, and had a good grip); *Oldring v. Metropolitan Life Ins. Co.*, 492 F. Supp. 994 (D.N.J. 1980) (finding an accident where owner experienced in use of gun, after having examined the gun and thinking it was empty, pointed and fired the gun at his head, killing himself); *Knight v. Metropolitan Life Ins. Co., supra*, (finding accidental the death of professional diver after diving off the Coolidge Dam; he previously had completed the same dive without injury).

Finally, if the fact-finder, in attempting to ascertain the insured's actual expectation, finds the evidence insufficient to accurately determine the insured's subjective expectation, the fact-finder should then engage in an objective analysis of the insured's expectations. *See Hoffman*, 669 P.2d at 419. In this analysis, one must ask whether a reasonable person, with background and characteristics similar to the insured, would have viewed the injury as highly likely to occur as a result of the insured's intentional conduct. *See City of Carter Lake v. Aetna Cas. and Sur. Co.*, 604 F.2d 1052, 1058-59 & n.4 (8th Cir. 1979). An objective analysis, when the background and characteristics of the insured are taken into account, serves as a good proxy for actual expectation. Requiring an analysis from the perspective of the reasonable person in the shoes of the insured fulfills the axiom that accident should be judged from the perspective of the insured. *See Sanders v. Prudential Ins. Co.*, 697 S.W.2d 80 (Tex. Ct. App. 1985).

D.

Applying these concepts, we believe that the magistrate did not err in ruling that Wickman's death was not an accident within the terms of the insurance policy.[5] The

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[5] Because the magistrate decided there was no accident in this case, and we affirm on this basis, he did not and we need not reach the question of whether Wickman's death was actually a suicide. The failure to reach this issue makes the presumption relating to the death certificate and the presumption

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linchpin of the magistrate's findings was his conclusion that "Wickman knew or should have known that serious bodily injury or death was a probably [sic] consequence substantially likely to occur as a result of his volitional act in placing himself on the outside of the guardrail and hanging on with one hand." This finding equates with a determination either that Wickman expected the result, or that a reasonable person in his shoes would have expected the result, and that any other expectation would be unreasonable.

If he actually expected the result, even if he did not specifically intend it, then his actual expectations make his death *not* accidental. It appears that the magistrate hedged his opinion with the "should have known" language because the third scenario, that Wickman went out on the rail for reasons other than to injure or kill himself, was undeveloped and unsubstantiated at trial. The plaintiff never proffered a specific alternate explanation for Wickman's actions, leaving the magistrate to conjecture.[6]

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against suicide, relied upon extensively by the plaintiff, irrelevant. We do note, in passing, that these presumptions are not irrebuttable, and only exist to shift the burden of going forward with the evidence to the party arguing suicide. *See* Fed. R. Evid. 301; *Republic National Life Ins. Co. v. Heyward*, 536 S.W.2d 549 (Tex. 1976); *Equitable Life Assur. Soc. v. Irelan*, 123 F.2d 462, 464 (9th Cir. 1941).

[6] At trial the plaintiff explained her husband's actions as an errant ending up on the outside of the guardrail, making the action which led to the injury unintentional and unexpected, thus accidental. The magistrate directly found that Wickman

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Under such circumstances, it certainly can be said that there was insufficient evidence, assuming *arguendo*, as did the magistrate, the accuracy of the third scenario, to reach a conclusion as to Wickman's actual expectation. Thus, the magistrate appropriately engaged in an objective analysis.

The magistrate's conclusion that Wickman "should have known" that death or injury was "substantially likely to occur" is not in error either legally or factually. Legally, "should have known" is synonymous with, if not even a higher standard than, the reasonable expectation standard we promulgated above. Similarly, "substantially likely to occur" is an equivalent, if not tougher, standard to "highly likely to occur." Thus, the magistrate applied an acceptable legal standard, and did not commit an error of law.

The plaintiff has never seriously challenged the accuracy of the factual conclusion. She largely concedes that a reasonable person in Wickman's shoes would have expected to die or be seriously injured as a result of climbing over the guardrail and hanging on with only one hand. Such a concession, given the height of the bridge, the narrow foothold, that Wickman possessed no extraordinary gymnastic, acrobatic, or other athletic skills, and the absence of evidence that would have

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intentionally climbed over the guardrail, thus rejecting this interpretation of the incident. This finding of fact, which is not clearly erroneous, is not challenged by the widow.

enabled him to hold on, is not surprising. Thus, the magistrate's conclusion that Wickman's death was to be reasonably expected is not clearly erroneous.

IV.

In sum, we conclude that this case is governed under ERISA, and that applying federal common law under ERISA, Paul Wickman's death did not constitute an accident within the terms of his group accident insurance policy. Wickman either subjectively expected serious injury, or the evidence was inconclusive as to his subjective expectation. Objectively, he reasonably should have expected serious injury when he climbed over the guardrail and suspended himself high above the railroad tracks below by hanging on to the guardrail with only one hand.

Accordingly, the judgment below is AFFIRMED.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

MARY JANE WICKMAN

V.

CIVIL ACTION
NO. 86-1895-WF

NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY

FINDINGS OF FACT AND
CONCLUSIONS OF LAW

COLLINGS, U.S.M.

INTRODUCTION

This action was instituted by the plaintiff, Mary Jane Wickman (hereinafter "Mrs. Wickman"), as a named beneficiary of a group policy of insurance in effect at the time of the death of her husband, Paul P. Wickman (hereinafter "Mr. Wickman"). The policy of insurance, issued by the defendant, Northwestern National Life Insurance Company (hereinafter "Northwestern"), insured Mr. Wickman for life insurance and accidental death benefits. Under the terms of the policy, Northwestern agreed to pay the named beneficiary, in this instance Mrs. Wickman, one hundred five thousand dollars ($105,000) if Mr. Wickman died while the policy was in force and, further, to double that amount if Mr. Wickman's death was the result of an accident. Northwestern paid Mrs. Wickman ordinary death benefits in accordance with the policy provisions following Mr. Wickman's demise but denied her claim of entitlement to an additional one hundred five thousand dollars for accidental death benefits. Northwestern's denial of Mrs. Wickman's claim for accidental death benefits precipitated the instant litigation.

Upon the consent of the parties, this case was referred to the undersigned for all purposes, including trial and the entry of judgment pursuant to 28 U.S.C. § 636(c) by order of the District Judge to whom this case is assigned.

## PRE-TRIAL PROCEEDINGS

The plaintiff's initial complaint was framed as an action under a common law theory of breach of contract. The defendant moved to dismiss the complaint, arguing that Mrs. Wickman's state law claim was pre-empted by the provisions of the federal Employee Retirement Income Security Act of 1974 (ERISA). After considering the current state of statutory and case law on the issue, the Court allowed Northwestern's motion to dismiss, concluding that ERISA applied and, therefore, pre-empted the plaintiff's state law claim for breach of contract. *Wickman v. Northwestern National Life Insurance Co.*, C.A. 86-1895-WF, D. Mass, 10/22/87 (slip option). In the wake of this decision, the plaintiff, without objection from the defendant, filed an amended complaint incorporating several claims arising under ERISA. The defendant filed an amended answer and the case continued apace.

The determination that Mrs. Wickman's cause of action was governed by ERISA significantly altered the complexion of this litigation. The plaintiff had claimed a trial by jury in her original complaint; the parties agreed that there was no right to a jury trial in an action for benefits brought under ERISA. Further, the applicability of ERISA's enforcement scheme prompted the filing of a motion *in limine* by the defendant raising issues not fully

addressed by the Supreme Court or the First Circuit as of that date. On these questions, the parties were not in accord.

The first issue was what the plaintiff's burden of proof should be under ERISA's enforcement scheme. In a breach of contract action under state law, the plaintiff would have to demonstrate by a preponderance of the evidence that Mr. Wickman's death was accidental and, thus, that Northwestern had breached the terms of the policy by refusing to pay accidental death benefits. On the other hand, as the Court stated in its Memorandum On Defendant's Motion To Dismiss (#28), under ERISA, the plaintiff's burden would be to show that the decision to deny benefits by the insurance company as a fiduciary was "arbitrary and capricious." However, the plaintiff argued, notwithstanding the applicability of ERISA's provisions, that the arbitrary and capricious standard was inappropriate. Rather, the plaintiff maintained that state law, i.e., the preponderance of the evidence standard, should govern the burden of proof when the issue is interpretation of insurance policies regarding payment of benefits.

The second issue raised was what the scope of the trial should be. The defendant contended that the Court should limit its consideration to the evidence that was before Northwestern when the decision to deny accidental death benefits was made. This circumscribed review, of course, was in tandem with the defendant's position that the Court need only decide if the defendant's denial of benefits was arbitrary and capricious based on the evidence it possessed at the time. Conversely, the plaintiff argued that the Court should conduct a trial *de novo* to

consider all the evidence that the parties might wish to present.

In light of the plaintiff's continued strenuous objection to the applicability of ERISA to her claims, as well as the dearth of precedent on these issues at the time, the Court was not wont to foreclose the plaintiff from establishing as complete a record as possible for any future appeal while simultaneously avoiding the potential necessity of a retrial. Moreover, the need to decide the issues pre-trial was obviated by the fact that the case proceeded to trial with the Court sitting without a jury. Thus, reserving on the questions of burden of proof and the scope of the proceeding the Court heard all the evidence the parties sought to present as if it were a trial *de novo* over the course of a four-day trial in February, 1988.

While the case was *sub judice*, the Supreme Court on February 21, 1989, decided the case of *Firestone Tire and Rubber Company v. Burch*, ___ U.S. ___, 109 S.Ct. 948 (1989) and held that:

> [F]or purposes of actions under [29 U.S.C.] § 1132(a)(1)(B), the *de novo* standard of review applies regardless of whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest.

*Id.* at 956.

Since Mrs. Wickman's action is one under 29 U.S.C. § 1132(a)(1)(B) ("to recover benefits due . . . under the terms of [the plan]"), the *de novo* standard applies.

Having considered the testimony of the witnesses, the exhibits admitted into evidence and the arguments of

counsel and reviewing the decision to deny benefits on a *de novo* basis, the Court finds that the plaintiff has not carried her burden, i.e. demonstrated by a preponderance of the evidence that Mr. Wickman's death was accidental within the meaning of the insurance policy, and therefore, that Northwestern breached the contract by refusing to pay accidental death benefits.

## FINDINGS OF FACT

1. The life of Mr. Wickman was insured through group life policy No. GL-18090-4 purchased through his employer, the Dexter Corporation, from the defendant, Northwestern. (Stipulation of Uncontested Facts #38 ¶ 1)

2. Mr. Wickman died on July 11, 1984 while group life policy No. GL-18090-4 was in effect. (Stipulation #38 ¶ 2)

3. Mrs. Wickman was a named beneficiary of group life policy No. GL-18090-4 at the time of the death of her husband, Mr. Wickman. (Amended Complaint #33 ¶ 8; Answer to Amended Complaint #34 ¶ 8)

4. Group life policy No. GL-18090-4 provides for the payment of ordinary life insurance benefits for all causes of death upon written proof of the insured's death while the policy was in force. (Plaintiff's Exh. #17, section entitled "LIFE INSURANCE" at p. 7)

5. On or about December 10, 1984, Northwestern paid to the plaintiff the sum of one hundred five thousand dollars ($105,000), plus interest from July 11, 1984, as the ordinary death benefit under group policy No. GL-18090-4. (Stipulation #38 ¶ 3)

6. Group life policy No. GL-18090-4 provides for the payment of accidental death and dismemberment insurance benefits if the insured losses [sic] his life, limb or sight due to accidental injury while the

policy was in force. (Plaintiff's Exh. 17, section entitled "LIFE INSURANCE" at p. 10)

7. Group life policy No. GL-18090-4 provides that accidental death and dismemberment insurance benefits will not be paid "for loss directly or indirectly caused by . . . (s)uicide or intentionally self-inflicted injury, whether [insured is] sane or insane." (Plaintiff's Exh. #17, section entitled "LIFE INSURANCE" at p. 10)

8. Group life policy No. GL-18090-4 defines "accident" as "an unexpected, violent and sudden event." (Plaintiff's Exh. 317, section entitled "LIFE INSURANCE" at p. 13)

9. Group life policy No. GL-18090-4 provides for an accidental death and dismemberment insurance benefit of one hundred five thousand dollars if Mr. Wickman's death was due to accidental injury. (Amended Complaint #33 ¶ 10; Answer To Amended Complaint #34 ¶ 10)

10. By letter dated July 16, 1985, plaintiff submitted to Northwestern a supplemental proof of loss in connection with a claim for the accidental death and dismemberment insurance benefit under group life policy No. GL-18090-4. (#38 ¶ 4; Plaintiff's Exh. #1)

11. The plaintiff submitted to Northwestern, together with the supplemental proof of loss dated July 16, 1985, the following documents: a form entitled "Affidavit of Beneficiary" (Plaintiff's Exh. #2); a death certificate (Plaintiff's Exh. #4); a newspaper article entitled "Fall From Bridge Results In Death Of Needham Man" (Plaintiff's Exh. #5); an obituary of Paul P. Wickman (Plaintiff's Exh. #6); and a two-page statement dated August 31, 1984 by Anne M. Wickman, the decedent's sister (Plaintiff's Exh. #7). (#38 ¶¶ 5-10)

12. The original death certificate of Mr. Wickman dated July 13, 1984 stated the cause of death to be: "Massive internal hemorrhage secondary to fracture –

dislocation of pelvis – caused by 90 foot fall from bride (sic) – while in depressed mental state. Suicide." (Defendant's exhibit #2)

13. The amended death certificate of Mr. Wickman dated June 26, 1985 stated the cause of death to be: "Massive internal hemorrage (sic) secondary to fracture – dislocation of pelvis – caused by 90 foot fall from bridge." (Plaintiff's Exh. #3)

14. An accidental death investigation report was submitted to Northwestern on or about November 27, 1984 by Northern Service Bureau, Ltd., a firm engaged by Northwestern to investigate the circumstances of the death of Mr. Wickman. (Defendant's Exh. #14)

15. By letter dated December 12, 1985, Northwestern denied the plaintiff's claim for accidental death and dismemberment insurance benefits provided under group life policy No. GL-18090-4. (#38 ¶ 11; Plaintiff's Exh. #21)

16. On July 11, 1984 at or around 4:00 P. M., Michael Blanchette was driving southbound on Route 495 in Middleborough, Massachusetts.

17. As Michael Blanchette approached a bridge near the overpass of Route 105, he observed a parked car, later identified as that of Mr. Wickman, in the right-hand side breakdown lane with its flashers on.

18. As Michael Blanchette crossed the bridge, he observed an elderly man, later identified as Mr. Wickman, facing in a northerly direction standing on the outside of the guard rail holding on with his right hand.

19. The distance from the parked car in the breakdown lane to the point on the bridge where Paul P. Wickman was holding on to the guard rail was approximately 20 to 30 yards, one third of the length of the bridge. (Plaintiff's exhibit #16)

20. When Michael Blanchette looked again, Mr. Wickman was no longer holding on to the railing and was on his way to the ground below the bridge.

21. The bridge upon which Michael Blanchette saw Mr. Wickman passes over railroad tracks approximately 40 to 50 feet below. (Plaintiff's Exhs. ##13, 15; Defendant's Exhs. ## 8, 9, 10)

22. Michael Blanchette stopped his automobile, climbed down the embankment and found Mr. Wickman lying on the railroad tracks below the bridge.

23. The bridge upon which Michael Blanchette saw Mr. Wickman has a guard rail that is approximately 3 to 4 feet high with no outside lip or ledge. (Defendant's Exh. #10)

24. Mr. Wickman was taken by ambulance to St. Luke's Hospital in Middleborough, Massachusetts. (Plaintiff's Exhs. ##9, 10)

25. Mr. Wickman was transferred to Brockton Hospital where he died in the Emergency Room. (Plaintiff's Exh. #10)

26. Mr. Wickman's car was towed from the breakdown lane to a secure lot by the Massachusetts State Police on July 11, 1984.

27. Mr. Wickman's car had no mechanical problems when it was retrieved by his family on July 12, 1984.

## CONCLUSIONS OF LAW

As the Court indicated to counsel at the post-trial closing arguments hearing, the facts of this case admit to no other conclusion but that Mr. Wickman intended to put himself on the outside of the guard rail on the bridge over the railroad tracks on Route 495 in Middleborough, Massachusetts on July 11, 1984. Mr. Wickman was observed by Michael Blanchette 20 to 30 yards away from

his car on the bridge at a point where the overpass spanned railroad tracks 40 to 50 feet below. Aside from the fact that his car was later found to be in working order, the suggestion that Mr. Wickman was on the bridge in search of aid for his broken down vehicle and somehow found himself on the outside of the guard rail is quite simply not plausible due to the physical structure of the bridge itself.

There is no outside ledge or even lip upon which Mr. Wickman could have been walking to look for help. As the photographs admitted as exhibits at trial show, to stand on the outside of the guard rail a person's feet would literally have to be directly under the rail. The guard rail itself at the point where the bridge crosses the railroad tracks is 3 to 4 feet high, constructed of intermittent vertical posts crossed by three continuous horizontal railings. It is not reasonable to believe that Mr. Wickman either fell over or through the guard rail, or otherwise came to be on the outside through mistake or inadvertence. Clearly, it would take a conscious effort to climb over or through the guard rail on the bridge. Thus, this is a case in which the insured was injured as a consequence of his own intentional act. The issue to be determined is whether Mr. Wickman's injury and death resulted from an accident within the meaning of the group life insurance policy under the law.

The term "accident" in the insurance policy is defined as "an unexpected, external, violent and sudden event." This definition is similar to that employed by the courts in Massachusetts, i.e., "[i]n its common signification the word (accident) means an unexpected happening

without intention or design." *Quincy Mutual Fire Insurance Company v. Abernathy*, 393 Mass. 81, 83, 469 N.E.2d 797, 799 (1984), quoting from *Beacon Textiles Corp. v. Employers Mut. Liab. Ins. Co.*, 355 Mass. 643, 646, 246 N.E.2d 671 (1969). Under Massachusetts law, the term "accident" has been broadly construed. The Supreme Judicial Court

> . . . consistently has stated that the resulting injury which ensues from the volitional act of an insured is still an "accident" within the meaning of an insurance policy if the insured does not specifically intend to cause the resulting harm or is not substantially certain that such harm will occur.

*Quincy Mutual Fire Insurance Company v. Abernathy, supra*, 393 Mass. at 89, 469 N.E.2d at 799. (citation omitted)

Under this standard, the fact that Mr. Wickman ultimately died from injuries ensuing from his own volitional act does not preclude the possibility that the death was accidental.

As the Court proposed to counsel, there are only three possible scenarios to explain what occurred on the bridge in the circumstances of this case. First, Mr. Wickman intentionally put himself outside the guard rail and thereafter let go intending to kill himself. Given these facts, there would clearly be no right to accidental death benefits. Second, Mr. Wickman intentionally put himself outside the guard rail and thereafter let go intending to cause himself serious bodily injury. Again, there would be no insurance coverage in these circumstances under the terms of the policy. The third possibility is that Mr. Wickman intentionally put himself outside the guard rail

and through some mistake or inadvertence fell to the ground below. In this last possibility, Mr. Wickman would not have any specific intent to injure or kill himself, and, under the law, the resultant death could still be an accident.

But even assuming that Mr. Wickman had no specific intent to injure or kill himself, the Court finds that he intentionally put himself outside the guard rail on the bridge over the railroad tracks and, further, that the harm that befell him was substantially certain to happen. This is not a case wherein the insured intentionally did an act with some unexpected result. *See*, e.g., *Dow v. United States Fidelity & Guaranty Co.*, 297 Mass. 34, 7 N.E.2d 426 (1937) (insured died as a result of immersion into scalding bath water). Here, it was reasonably foreseeable to the insured that in climbing over a 3 to 4 foot guard rail with no ledge on a bridge spanning 30 to 40 feet above a set of railroad tracks that he had placed himself in such a position that serious bodily injury was substantially likely to occur. The injuries that did result, if not the death, were of the type which would be expected to occur. The Court finds as a matter of law that the insured did not lose his life due to an accident as that term is defined under the policy and Massachusetts law.

The facts of the instant case are similar to those in *Kinavey v. Prudential Ins. Co. of America*, 27 A.2d 286 (Pa., 1942). In *Kinavey*, the insured was a 22-year old man who fell from a bridge into the Monogahela River and was drowned. The evidence showed that one evening the insured became intoxicated and was staggering but speaking coherently. Two friends offered to accompany him home, and all three proceeded to walk across the

bridge. After reaching the far end of the bridge approximately one mile away, the insured left his friends, crossed the four lands of the bridge to the other side, and proceeded back in the direction from which they had just come. The insured climbed over "a substantial metal railing 44 inches high" onto a 4 inch ledge on the outside of the rail. He proceeded to perform various stunts on this ledge until he ultimately lost his balance, fell into the river and drowned.

The court assumed that the death was not intentional, there being no facts or circumstances indicative of suicide. However, recovery of accidental death benefits was denied based on

> . . . the fact that death was not an unusual or unexpected result of the voluntary means employed. An entirely different situation would have been presented if the iron railing had given way or the ledge upon which he was standing had crumbled under his feet or some greasy substance had caused his feet to slip. No unforeseen element combined with the deceased's acts; no agency independent of his own acts contributed to his death. His every act was voluntary and though his behavior was extraordinary, falling from the bridge was a foreseeable probable result naturally following from his reckless act.

*Kinavey v. Prudential Ins. Co. of America, supra,* 27 A.2d at 288. Like the insured in *Kinavey,* Mr. Wickman voluntarily placed himself in such a position of danger "that falling from the bridge was not only foreseeable by him, but was almost inevitable." *Id.* at 287.

Given the physical characteristics of the bridge, i.e., the height and substance of the guard rail, the absence of

an outside ledge, the distance to the ground below, the Court finds that Mr. Wickman knew or should have known that serious bodily injury or death was a probable consequence substantially likely to occur as a result of his volitional act in placing himself on the outside of the guard rail and hanging on with one hand. *See, e.g. Runge v. Metropolitan Life Insurance Company*, 537 F.2d 1157, 1159 (4 Cir., 1976); *Sigler v. Mutual Benefit Life Insurance Company*, 663 F.2d 49, 49 (8 Cir., 1981); *International Underwriters, Inc. v. Home Insurance Company*, 662 F.2d 1084, 1087 (4 Cir., 1981). Mr. Wickman's loss of life was not due to an accident as that term is defined in group policy No. GL-18090-4 or under the law.

In sum, the Court finds that the plaintiff has failed to prove by a preponderance of the evidence that her husband's death was accidental.

## CONCLUSION

These findings of fact and conclusions of law dispose of all the plaintiff's claims. Northwestern has neither breached it contract or [sic] breached its fiduciary duties with respect to the denial of accidental death benefits to Mrs. Wickman. Judgment shall enter for the defendant in this cause.

/s/ Robert B. Collings
ROBERT B. COLLINGS
United States Magistrate

October 23, 1989.

**United States District Court**

_____ DISTRICT OF MASSACHUSETTS

MARY JANE WICKMAN

V.

NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY.

**JUDGMENT IN A CIVIL CASE**

CASE NUMBER: 86-1895-WF

COLLINGS, U.S.M.

[ ] **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

[XX] **Decision by Court.** This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

Judgment for the defendant; costs to defendant.

October 23, 1989
*Date*

ROBERT J. SMITH, JR.
*Clerk*

/s/ Jean M. Pandolfo
Jean M. Pandolfo
*(By) Deputy Clerk*

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

MARY JANE WICKMAN

V.

NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY

CIVIL ACTION NO. 86-1895-WF

MEMORANDUM ON DEFENDANT'S MOTION TO DISMISS (#18)

COLLINGS, U.S.M.

This action was instituted by the plaintiff, Mary Jane Wickman (hereinafter "Mrs. Wickman"), as a named beneficiary of a group policy of insurance in effect at the time of death of her husband, Paul P. Wickman (hereinafter "Mr. Wickman"). The policy of insurance, group policy number GL-19090-4, had been issued by the defendant Northwestern National Life Insurance Company (hereinafter "Northwestern") to the Hysol Division of Dexter Corporation, Mr. Wickman's employer at the time of his demise. The premiums in payment of this policy were paid to Northwestern by the Dexter Corporation, Hysol Division, and its employees. The policy insured Mr. Wickman for life insurance and accidental death benefits. Under the terms of the policy, Northwestern agreed to pay the named beneficiary, in this instance Mrs. Wickman, one hundred five thousand dollars if Mr. Wickman died while the policy was in force and, further, to double that amount if Mr. Wickman's death was the result of an accident.

Following Mr. Wickman's death on July 11, 1984, Mrs. Wickman submitted a notice of claim and proof of

loss to Northwestern seeking payment for ordinary death benefits. The claim was honored, and Northwestern paid Mrs. Wickman one hundred five thousand dollars in satisfaction. Thereafter, Mrs. Wickman submitted a supplemental proof of loss to establish that Mr. Wickman's death was caused by accidental means as defined in the insurance policy and that, as a result, she was entitled to accidental death benefits in the sum of an additional one hundred five thousands dollars. Northwesterns' denial of that claim for accidental death benefits precipitated the instant litigation.[1]

Mrs. Wickman's complaint alleges that Northwestern breached the contract of insurance by failing to pay her the accidental death benefits under the terms of the group insurance policy. Jurisdiction is based on diversity of citizenship. Northwestern has moved to dismiss the complaint on the grounds that Mrs. Wickman's breach of contract claim which is based on state law is pre-empted by the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).[2]

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[1] The parties have consented to have the case referred to the undersigned for all purposes, including trial and the entry of judgment, pursuant to 28 U.S.C. § 636(c) and the District Judge to whom the case is assigned has entered an order of reference pursuant to the consent.

[2] In addition to its Memorandum Of Law In Support Of Its Motion To Dismiss (#20), Northwestern has submitted the Affidavit of James R. Hanson (#19) to which a copy of the group policy of insurance, GL-18090-4, is attached. Mrs. Wickman has raised no objection to the Court considering either the affidavit or the attachment thereto. This is not surprising since

(Continued on following page)

Whether a common law cause of action for breach of contract is pre-empted by ERISA depends on whether it "relate[s] to . . . [an] employee benefits plan." ERISA, § 514(a), 29 U.S.C. § 1144(a). The Supreme Court has recently determined that a claimant's common law contract and torts claims asserting the improper processing of a claim for benefits similar to that raised by the plaintiff herein did "relate to [an] employee benefit plan" and, therefore, were pre-empted by § 514(a) and not saved by § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). *Pilot Life Insurance Co. v. Dedeaux*, ___ U.S. ___, 107 S.Ct. 1549, 1558 (1987). On the same date, the Supreme Court determined that the claimant's remedies were exclusively those detailed in ERISA's civil enforcement scheme, § 502(a), 29 U.S.C. § 1132(a). *Metropolitan Life Insurance Company v. Taylor*, ___ U.S. ___, 107 S.Ct. 1542 (1987). In neither of these cases was there any question that employee benefits plans had been established by the employers and were in effect at the time that the claims were advanced. *See, Dedeaux v. Pilot Life Insurance Company*, 770 F.2d 1311, 1312 (5 Cir., 1985) (" . . . a long term disability benefits plan Entex had established . . . was in effect"); *Pilot Life Insurance Company v. Dedeaux, supra*, 107 S.Ct. at 1551 ("Entex had at this time a long term disability employee benefit plan . . . "); *Taylor v. General Motors Corporation*, 763 F.2d 216, 218 (6 Cir., 1985) ("The group insurance policy . . . is a part of GMC's employee benefits program

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(Continued from previous page)

the motion to dismiss raises questions of law; the underlying facts are, in essence, undisputed. The Court, therefore, will treat the motion to dismiss as a motion seeking summary judgment in accordance with Rule 12(b), F.R. Civ. P.

established under ERISA."); *Taylor v. General Motors Corporation, supra,* 107 S.Ct. at 1545 ("General Motors Corporation . . . has set up an employee benefit plan subject to the provisions of ERISA . . . "). In the instant case, Mrs. Wickman does not dispute the holdings of these two Supreme Court cases; rather, she contends that they are simply not applicable because Mr. Wickman's employer had not set up an employee benefit plan as that term is used in ERISA. Northwestern contends that under relevant case law, an employee benefit plan was set up and, consequently, Mrs. Wickman's state law contract claim is pre-empted.

It follows that a determination of whether Mrs. Wickman's claim is pre-empted by ERISA turns solely on the question whether Mr. Wickman's employer established an employee benefits plan within the meaning of ERISA's provisions. If such a plan was established, Mrs. Wickman's breach of contract claim is pre-empted; if no plan was established, Mrs. Wickman's claim for breach of contract stands.

The applicable statute provides as follows:

> . . . [ERISA] shall apply to any employee benefit plan if it is established or maintained–
>
> (1) by any employer engaged in commerce or in any industry or activity affecting commerce; or
>
> (2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or
>
> (3) by both.

ERISA § 4(a), 29 U.S.C. § 1003(a).

The statute further provides that:

> The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

ERISA § 3(3), 29 U.S.C. § 1002(3).

As the Supreme Court has noted, these statutory definitions are "tautological". *Fort Halifax Packing Company, Inc. v. P. Daniel Coyne*, ___ U.S. ___, 107 S.Ct. 2211, 2216 (1987). The pertinent type of plan in the context of this case would be an "employee welfare benefit plan" or "welfare plan" which is defined by statute as

> . . . any plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) . . . benefits in the event of sickness, accident, disability, death or unemployment . . .

ERISA § 3(1), 29 U.S.C. § 1002(1).

The five constituent statutory prerequisites of a welfare benefit plan are:

> (1) a "plan, fund or program" (2) established or maintained (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing . . . accident [or] . . . death . . . benefits . . . (5) to participants or their beneficiaries.

*Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11 Cir., 1982) (*en banc*); *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc.*, 805 F.2d 732, 738 (7 Cir., 1986).

As the *Donovan* court noted, the meaning of the third, fourth and fifth requirements are straightforward and readily understood. Indeed, there is no dispute that these last three prerequisites of an employee welfare benefit plan have been met in this case. The Dexter Corporation, Hysol Division, was the policyholder of a group life insurance policy, GL-18090-4, issued by Northwestern. The premiums for this group policy were paid, at least in part, by the Dexter Corporation.[3] The purpose of the insurance policy was to provide for the payment of ordinary and accidental death benefits to the Hysol Division's participating employees or their named beneficiaries. What is disputed is whether the first two requirements of § 3(1) are satisfied, i.e., that there be a plan, fund or program established or maintained by the Dexter Corporation.

Although these two prerequisites are ill-defined by statute, the Eleventh Circuit has formulated a standard that is often cited with approval:

> In summary, a "plan, fund or program" under ERISA is established if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits.

*Donovan v. Dillingham, supra*, 688 F.2d at 1371.

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[3] ERISA covers a plan where both the employer and its employees contribute to the payment of the total premium for an insurance policy. *See e.g., Pilot Life Insurance Company v. Dedeaux, supra*, 107 S.Ct. at 1551.

Later cases which have been faced with the same issue and which rely on the decision in *Donovan v. Dillingham* include *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc.*, 805 F.2d 732, 739 (7 Cir., 1986), *Harris v. Arkansas Book Company*, 794 F.2d 358, 360 (8 Cir., 1986), *Scott v. Gulf Oil Corporation*, 754 F.2d 1499, 1504 (9 Cir., 1985) and *Local Union 2134, United Mine Workers of America v. Powhatan Fuel, Inc.*, 640 F.Supp. 731, 734 (N.D. Ala. 1986).

It has also been held that a formal, written plan or program is not a prerequisite to a finding that such a plan under ERISA has been established. *Donovan v. Dillingham, supra*, 688 F.2d at 1372; *California Hospital Association v. Henning*, 569 F.Supp. 1544, 1545-1546 (C.D. Cal. 1983) (citing *Donovan*); *Scott v. Gulf Oil Corporation, supra*, 754 F.2d at 1504 (citing *Donovan* and *California Hospital Association*). Moreover, contrary to Mrs. Wickman's argument, an employer's failure to comply with the administrative and reporting requirements of the Act does not eviscerate ERISA coverage of a plan if one, in fact, has been established, or evince the lack of a plan in the first instance. *Donovan v. Dillingham, supra*, 688 F.2d at 1372; *Blau v. Del Monte Corporation*, 748 F.2d 1348, 1352 (9 Cir., 1984) (citing *Donovan* as well as other cases), *cert. denied*, 474 U.S. 865 (1985); *Scott v. Gulf Oil Corporation, supra*, 754 F.2d at 1503 (citing *Blau*); *Adam v. Joy Manufacturing Company*, 651 F.Supp. 1301, 1306 (D. N.H. 1987) (citing *Blau*). Not only are these numerous reporting and fiduciary requirements, i.e., 29 U.S.C. §§ 1021-1030 and 29 U.S.C. §§ 1101-1113, not incorporated into ERISA's provisions respecting coverage or definitions, 29 U.S.C. § 1003a and 29 U.S.C. § 1002(1), as a policy consideration:

> . . . it would be incongruous for persons establishing or maintaining informal or unwritten employee benefit plans, or assuming the responsibility of safeguarding plan assets, to circumvent the Act merely because an administrator or other fiduciary failed to satisfy reporting or fiduciary standards.

*Donovan v. Dillingham, supra,* 688 F.2d at 1371 (and cases cited therein); *Scott v. Gulf Oil Corporation, supra,* 754 F.2d at 1503 (citing *Blau*); *Gilbert v. Burlington Industries, Inc.,* 765 F.2d 320, 328-9 (2 Cir., 1985) (citing *Donovan*), *aff'd mem.,* ___ U.S. ___, 106 S.Ct. 3267 (1986).

The focus of the inquiry is whether the intent or decision to establish a plan or program "has become a reality." *Donovan v. Dillingham, supra,* 688 F.2d at 1371; *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc., supra,* 805 F.2d at 739.

There is no question that the purchase of insurance in and of itself is insufficient to demonstrate conclusively that a plan has been established, although it is some evidence of an intent to establish a plan. *Donovan v. Dillingham, supra,* 688 F.2d at 1373. However, as the Court noted in the *Donovan* case,

> . . . the purchase of a group policy or multiple policies covering a class of employees offers substantial evidence that a plan, fund or program has been established. (footnote omitted)

*Id. See also Local Union 2134, United Mine Workers of American v. Powhatan Fuel, Inc., supra,* 640 F.Supp. at 734 (citing *Donovan*).

Having reviewed the principles set forth in the relevant statutory provisions and the case law, the Court's

next step is to apply these principles to the undisputed facts in the instant case.

It is clear that a reasonable person could determine the intended benefits, i.e., life and accidental death benefits. According to the allegations of the complaint, Mrs. Wickman was not only cognizant of these benefits, she applied for both. Complaint (#1), ¶¶12 and 13. Referring to group policy GL-18090-4 as is permissible to glean certain essentials of a plan (*Donovan v. Dillingham, supra,* 688 F.2d at 1373), the class of beneficiaries is defined as "all active full time employees regularly working 32 hours or more per week in a permanent position" and the employees' named beneficiaries. Affidavit of James R. Hansen (#19) (Exhibit A at pp. 20 and 47) (hereinafter "Hansen Aff."). Again, Mrs. Wickman's actions evidence her understanding that she fell within the class of beneficiaries. Complaint, ¶¶7 and 8. While the complaint implies that the employer, the Hysol Division, Dexter Corporation, may have been the sole source of financing, it is elsewhere stated that both Dexter Corporation and its employees contributed to the payment of the group policy premiums. Compare, Complaint, ¶7 with Hansen Aff., ¶4. This is not an issue of material fact; there is no question that the Dexter Corporation was the policyholder of group policy GL-18090-4 and as such was responsible for the premium payments. Hansen Aff., Exhibit A at pp. 2 and 7. Moreover, it is clear that the policy was not maintained by the individual employees, but rather was, at a minimum, maintained by the employee group and the employer together, with Dexter Corporation providing at least a portion of the financing.

Hansen Aff., ¶4. Finally, the procedure for claiming benefits is set forth in the policy. Hansen Aff., Exhibit A at pp. 50-1. The allegations of the complaint reflect that Mrs. Wickman was able to ascertain what application procedure was and avail herself of it. Complaint, ¶¶12 and 13. Upon consideration of all these factors, it follows that an employee welfare benefit plan was established in this case and that ERISA applies.

From a different perspective, this conclusion is supported by a recent discussion by the Supreme Court in *Fort Halifax Packing Company, Inc. v. Daniel Coyne, supra,* 107 S.Ct. at 2219. The issue addressed in that case was whether a Maine severance pay statute was pre-empted by ERISA. The statute required employers in the state " . . . to provide a one-time severance payment to employees in the event of a plant closing." *Id.* at 2213. The employer argued that the statute was pre-empted by ERISA. The Court found that it was not. Justice Brennan, in the majority opinion, wrote:

> The Maine statute neither establishes nor requires an employer to maintain an employee benefit *plan*. The requirement of a one-time lump-sum payment triggered by a single event requires no administrative scheme whatsoever to meet the employer's obligation. The employer assumes no responsibility to pay benefits on a regular basis, and thus faces no periodic demands on its assets that create a need for financial coordination and control. Rather, the employer's obligation is predicated on the occurrence of a single contingency which may never materialize. The employer may well *never* have to pay the severance benefits. To the extent that the obligation to do so arises, satisfaction of that duty involves only making a single set of

> payments to employees at the time the plant closes. To do little more than write a check hardly constitutes the operation of a benefit plan. Once this single element is over, the employer has no further responsibility. The theoretical possibility of a one-time obligation in the future simply creates no need for an ongoing administrative program for processing claims and paying benefits.

*Id.* at 2218 (emphasis in original) (footnote omitted). The employer argued that the one-time payment of severance benefits upon the closing of a plant is analogous to the payment of death benefits to employees, and since death benefit payments to employees under a plan are covered by ERISA, the Maine statute was also, and, thus, preempted. Justice Brennan disposed of this argument in footnote 9 which is pertinent for purposes of the instant case:

> [9]Appellant notes that death benefits sometimes involve a one-time payment to beneficiaries, and that ERISA nonetheless defines an employee welfare benefit plan to include a program that pays such benefits. 29 U.S.C. § 1002(1). Thus, it contends the fact that the Maine statute requires a single payment does not mean that the statute does not establish a plan. This argument, however, misunderstands what it is that makes a plan a plan. While death benefits may represent a one-time payment from the perspective of the beneficiaries, the employer clearly foresees the need to make regular payments to survivors on an ongoing basis. The ongoing, predictable nature of this obligation therefore creates the need for an administrative scheme to process claims and pay out benefits, whether those benefits are received by beneficiaries in a lump sum or on a periodic

> basis. This is borne out by the fact that death benefits are included in appellant's retirement plan, with instructions on how eligibility is to be determined, benefit levels calculated, and disbursements made. App. 54-56. By contrast, appellant's statutory obligation did not prompt the establishment of any payment program, since there were no ongoing benefits to be paid.

*Id.* at 2219.

In the instant case, the plan to provide death benefits was established and maintained through the purchase of a group insurance policy. The particulars of the benefits, i.e., eligibility, the schedule of benefits, the claims procedure, were set out in the policy. While Northwestern retained discretion in processing claims and paying out benefits, the employer-policyholder nonetheless had the ongoing obligation to forward premium payments to preserve coverage. Whether the employer's administrative responsibility included merely writing company checks for periodic payments or collecting employee contributions to be matched by company funds to pay the premium costs, it was clearly not a one-time obligation. In other words, in making a plan a plan, it is significant that the employer undertook a predictable and continuing obligation to be met by some type of administrative mechanism or scheme for making regular and ongoing payments in order to maintain benefits for its employees.

The plaintiff contends that ERISA is not applicable in this case because there is no employee welfare benefit plan, only a mere "bare bones" insurance policy. As support for this proposition, the plaintiff relies on a broad reading of the decision in *Taggart Corp. v. Life & Health Benefits Administration*, 617 F.2d 1208 (5th Cir. 1980), *cert.*

*denied sub. nom. Taggart Corp. v. Efros*, 450 U.S. 1030 (1981). A discussion of the facts of *Taggart* is in order.

In that case, an organization named Security Multiple Employers Trust (SMET) provided group health insurance to employers too small to qualify for group insurance individually. Employers subscribed to SMET which then purchased insurance on behalf of all employer-subscribers; the subscribing employers made certain payments to SMET which then paid the insurance premiums out of the collective payments. Taggart Corporation, which had but one employee, was a subscriber to SMET. The sole employee sued under ERISA when the insurance carrier refused to pay health benefits to the employee's wife on the basis of alleged misrepresentations on the insurance application.

The Fifth Circuit affirmed the District Court's decision that SMET was not an "employee welfare benefit plan" within the meaning of ERISA. In this respect, the Court adopted the position of the Secretary of Labor who had filed an amicus brief. The Secretary of Labor, however, argued that ERISA was applicable because the employer-subscriber, i.e. the Taggart Corporation, had established a plan by subscribing to SMET. The Court wrote:

> We reject this [i.e., the Secretary of Labor's] suggestion. Considering the history, structure and purposes of ERISA, we cannot believe that that Act regulates bare purchases of health insurance where, as here, the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits.

*Taggart Corp. v. Life & Health Benefits Administration, supra,* 617 F.2d at 1211.

In the *Donovan* case, the Eleventh Circuit Court of Appeals had occasion to determine the scope of the *Taggart* decision and the extent to which it would be binding on that Circuit. The Eleventh Circuit agreed that SMET was not itself a "plan" under ERISA and also agreed, on the facts of *Taggart*, that the Taggart Corporation had not itself established an ERISA "plan" since it appeared from the decision of the District Court[4] that the sole employee of the corporation had purchased the insurance directly from SMET rather than through the Taggart Corporation. However, the Eleventh Circuit disavowed any adoption of a broader reading of the *Taggart* holding, writing:

> Although we agree with the holding in *Taggart*, we find the reasoning of the opinion that Taggart Corporation did not have a "plan, fund or program" encourages too broad an interpretation. If *Taggart* is interpreted to mean that ERISA does not regulate purchases of health insurance when there is no welfare plan, we agree. The purchase of insurance is only a method of implementing a plan, fund, or program and is evidence of the existence of a plan but is not itself a plan. If *Taggart* implies that an employer or employee organization that only purchases a group health insurance policy or subscribes to a MET to provide health insurance to its employees or members cannot be said to have established or maintained an employee welfare benefit plan, we disagree. To that extent

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[4] *Taggert (sic) Corporation v. Efros,* 475 F. Supp. 124 (S.D. Tex., 1979).

> *Taggart* shall no longer be binding in the Eleventh Circuit.

*Donovan v. Dillingham, supra,* 688 F.2d at 1375.

Mrs. Wickman's arguments are, in essence, based on the broader reading of the *Taggart* case which was rejected by the Eleventh Circuit in *Donovan*. In my view, *Donovan* is a correct statement of the law.

The plaintiff cites the cases of *Lederman v. Pacific Mutual Life Insurance Company,* 484 F.Supp. 1020, 1022 (C.D. Ca. 1980) and *Cate v. Blue Cross and Blue Shield of Alabama,* 434 F.Supp. 1187, 1190-1191 (E.D. Tenn. 1977) as precedent for the proposition that ERISA does not cover a claim by a participant in an employer's group health insurance plan against the insurance company that issued the policy. In *Lederman,* it was stipulated that the plaintiff was a participant in an "employee welfare benefit plan" within the meaning of ERISA. 494 F. Supp. at 1021. In *Cate,* the Court expressed no doubt that the plan under which the plaintiff was suing fell within the definition of an "employee benefit plan" under ERISA. 434 F. Supp. at 1189. In both cases, the Courts found no jurisdiction under ERISA to sue insurance companies from whom insurance had been purchased pursuant to such plans. Those holdings have clearly been rejected by the Supreme Court in *Pilot Life Insurance Company v. Dedeaux, supra,* which presented a virtually identical fact situation. In *Dedeaux,* an employee participant in the long term disability benefit employee plan established by his employer and insured by a group insurance policy sued the issuing insurance company under common law tort and contract principles. The Supreme Court held that the plaintiff's causes of action against the insurance company alleging

the improper processing of a claim for benefits under an ERISA employee benefit plan were pre-empted by § 514(a) of the Act, 29 U.S.C. § 1144(a) and not saved by § 514(b)(2)(A), 29 U.S.C. § 1114(b)(2)(A). *Pilot Life Insurance Company v. Dedeaux, supra,* 107 S.Ct. at 1558.

In sum, considering the current state of statutory and case law on the issue, there is no doubt that Ms. Wickman's state law claim is pre-empted by ERISA.

In reaching this conclusion, the Court takes note of certain consequences which flow from the ruling that the provisions of ERISA apply. The first is that Northwestern, as administrator, is a "fiduciary" under the statute and must "discharge [its] duties with respect to [the] plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries." ERISA, § 404(a)(1)(A)(i), 29 U.S.C. § 1104(a)(1)(A)(i). At the present time, Northwestern acknowledges that it is a fiduciary, at least to the extent that it has the ultimate responsibility to grant or deny a claim. Defendant's Reply Memorandum, Etc. (#22) pp. 3-4. This is in accord with the statute and case law. *See* ERISA, § 3(21)(A), 29 U.S.C. § 1002(21)(A); *Eversole v. Metropolitan Life Insurance Co., Inc.*, 500 F.Supp. 1162, 1164-66 (C.D. Cal., 1982); *Schulist v. Blue Cross of Iowa*, 553 F. Supp. 248, 251-2 (N.D. Ill., 1982); *McLaughlin v. Connecticut General Life Insurance Co.*, 565 F.Supp. 434, 441-2 (N.D. Cal., 1983). Although Northwestern now acknowledges that it is a fiduciary, there is nothing to suggest that Northwestern was aware that it had a fiduciary obligation to Mrs. Wickman at the time it acted on her claim. If Northwestern was not aware of its status as a fiduciary at the time the claim was denied, it is

possible that Mrs. Wickman has a basis for a cause of action for breach of fiduciary duty pursuant to ERISA, §§ 502(a)(2), 409(a), 29 U.S.C. §§ 1132(a)(2), 1109(a) in addition to the claim for denial of benefits. ERISA, § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

Mrs. Wickman contends that Northwestern should not be allowed to use ERISA as a sword against employees in light of the underlying policy behind the Act. In other words, Mrs. Wickman argues that Northwestern is seeking to have ERISA's enforcement scheme found applicable to her case so that her burden of proof at trial will be more stringent. In a breach of contract action under state law, her burden would be to show by a preponderance of the evidence that Mr. Wickman's death was accidental and, thus, Northwestern breached the policy for refusing to pay accidental benefits. If the Civil enforcement provisions of ERISA applied, she would have to show that the decision to deny benefits by the insurance company as a fiduciary was "arbitrary and capricious". It is true that:

> Congress enacted ERISA to protect working men and women from abuses in the administration and investment of private retirement plans and employee welfare plans.

*Donovan v. Dillingham, supra,* 688 F.2d at 1370.

It is also true that the Act reflects a Congressional balancing of varying interests. In other words:

> . . . ERISA was also crafted to protect the interests of employers by putting an end to conflict and inconsistent state regulation of employee benefit plans. *Shaw v. Delta Air Lines, Inc.,* 403 U.S. 85, 99, 105 and n. 25 (1983).

*Adam v. Joy Manufacturing Company, supra,* 651 F.Supp. at 1306. The Civil enforcement remedies reflect the same balancing. As the Supreme Court has noted, the ERISA remedial scheme:

> . . . represents a careful balancing of the need for prompt and fair settlement procedures against the public interest in encouraging the formation of employee benefit plans.

*Pilot Life Insurance Company v. Dedeaux, supra,* 107 S.Ct. at 1556.

At bottom, Mrs. Wickman's argument is that she would prefer to be left to her remedy under common law than to the remedies under ERISA. However, once it is determined that ERISA applies, pre-emption occurs and any relief must be obtained by invoking ERISA's civil enforcement provisions which Congress enacted and which represent its judgment as how to best balance the competing and various interests involved.

/s/ Robert B. Collings
ROBERT B. COLLINGS
United States Magistrate

October 22, 1987.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

MARY JANE WICKMAN

V.

NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY

CIVIL ACTION
NO. 86-1895-WF

ORDER

COLLINGS, U.S.M.

In accordance with the Memorandum, Etc. (#28) entered October 22, 1987, it is ORDERED that Count I of the Amended Complaint be, and the same hereby is, DISMISSED,

/s/ Robert B. Collings
ROBERT B. COLLINGS
United States Magistrate

November 16, 1987.

**§ 1022. Plan description and summary plan description**

(a)(1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

(2) A plan description (containing the information required by subsection (b) of this section) of any employee benefit plan shall be prepared on forms prescribed by the Secretary, and shall be filed with the Secretary as required by section 1024(a)(1) of this title. Any material modification in the terms of the plan and any change in the information described in subsection (b) of this section shall be filed in accordance with section 1024(a)(1)(D) of this title.

(b) The plan description and summary plan description shall contain the following information: The name and type of administration of the plan; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles,

and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title).

(Pub.L. 93-406, Title I, § 102, Sept. 2, 1974, 88 Stat. 841.)

**§ 1023. Annual reports**

**(a) Publication and filing**

(1)(A) An annual report shall be published with respect to every employee benefit plan to which this part applies. Such report shall be filed with the Secretary in accordance with section 1024(a) of this title, and shall be made available and furnished to participants in accordance with section 1024(b) of this title.

(B) The annual report shall include the information described in subsections (b) and (c) of this section and where applicable subsections (d) and (e) of this section and shall also include –

(i) a financial statement and opinion, as required by paragraph (3) of this subsection, and

(ii) an actuarial statement and opinion, as required by paragraph (4) of this subsection.

(2) If some or all of the information necessary to enable the administrator to comply with the requirements of this subchapter is maintained by –

(A) an insurance carrier or other organization which provides some or all of the benefits under the plan, or holds assets of the plan in a separate account,

(B) a bank or similar institution which holds some or all of the assets of the plan in a common or collective trust or a separate trust, or custodial account, or

(C) a plan sponsor as defined in section 1002(16)(B) of this title,

such carrier, organization, bank, institution, or plan sponsor shall transmit and certify the accuracy of such information to the administrator within 120 days after the end of the plan year (or such other date as may be prescribed under regulations of the Secretary).

(3)(A) Except as provided in subparagraph (C), the administrator of an employee benefit plan shall engage, on behalf of all plan participants, an independent qualified public accountant, who shall conduct such an examination of any financial statements of the plan, and of other books and records of the plan, as the accountant may deem necessary to enable the accountant to form an opinion as to whether the financial statements and schedules required to be included in the annual report by subsection (b) of this section are presented fairly in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year. Such examination shall be conducted in accordance with generally accepted auditing standards, and shall involve such tests of the books and records of the plan as are considered necessary by the independent qualified public accountant. The independent qualified public accountant shall also offer his opinion as to whether the separate schedules specified in subsection (b)(3) of this section and the summary material required under section 1024(b)(3) of this title present fairly, and in all material respects the information contained therein when considered in conjunction with the financial statements taken as a whole. The opinion by the independent qualified public accountant shall be made a part of the annual report. In a case where a plan is not required to file an annual report, the requirements of this paragraph shall not apply. In a

case where by reason of section 1024(a)(2) of this title a plan is required only to file a simplified annual report, the Secretary may waive the requirements of this paragraph.

(B) In offering his opinion under this section the accountant may rely on the correctness of any actuarial matter certified to by an enrolled actuary, if he so states his reliance.

(C) The opinion required by subparagraph (A) need not be expressed as to any statements required by subsection (b)(3)(G) of this section prepared by a bank or similar institution or insurance carrier regulated and supervised and subject to periodic examination by a State or Federal agency if such statements are certified by the bank, similar institution, or insurance carrier as accurate and are made a part of the annual report.

(D) For purposes of this subchapter, the term "qualified public accountant" means –

(i) a person who is a certified public accountant, certified by a regulatory authority of a State;

(ii) a person who is a licensed public accountant, licensed by a regulatory authority of a State; or

(iii) a person certified by the Secretary as a qualified public accountant in accordance with regulations published by him for a person who practices in States where there is no certification or licensing procedure for accountants.

(4)(A) The administrator of an employee pension benefit plan subject to the reporting requirement of subsection (d) of this section shall engage, on behalf of all

plan participants, an enrolled actuary who shall be responsible for the preparation of the materials comprising the actuarial statement required under subsection (d) of this section. In a case where a plan is not required to file an annual report, the requirement of this paragraph shall not apply, and, in a case where by reason of section 1024(a)(2) of this title, a plan is required only to file a simplified report, the Secretary may waive the requirement of this paragraph.

(B) The enrolled actuary shall utilize such assumptions and techniques as are necessary to enable him to form an opinion as to whether the contents of the matters reported under subsection (d) of this section –

(i) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations; and

(ii) represent his best estimate of anticipated experience under the plan.

The opinion by the enrolled actuary shall be made with respect to, and shall be made a part of, each annual report.

(C) For purposes of this subchapter, the term "enrolled actuary" means an actuary enrolled under subtitle C of subchapter II of this chapter.

(D) In making a certification under this section the enrolled actuary may rely on the correctness of any accounting matter under subsection (b) of this section as to which any qualified public accountant has expressed an opinion, if he so states his reliance.

**(b) Financial statement**

An annual report under this section shall include a financial statement containing the following information:

(1) With respect to an employee welfare benefit plan: a statement of assets and liabilities; a statement of changes in fund balance; and a statement of changes in financial position. In the notes to financial statements, disclosures concerning the following items shall be considered by the accountant: a description of the plan including any significant changes in the plan made during the period and the impact of such changes on benefits; a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with persons known to be parties in interest; a general description of priorities upon termination of the plan; information concerning whether or not a tax ruling or determination letter has been obtained; and any other matters necessary to fully and fairly present the financial statements of the plan.

(2) With respect to an employee pension benefit plan: a statement of assets and liabilities, and a statement of changes in net assets available for plan benefits which shall include details of revenues and expenses and other changes aggregated by general source and application. In the notes to financial statements, disclosures concerning the following items shall be considered by the accountant: a description of the plan including any significant changes in the plan made during the period and the impact of such changes on benefits; the funding policy (including policy with respect to prior service cost), and

any changes in such policies during the year; a description of any significant changes in plan benefits made during the period; a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with persons known to be parties in interest; a general description of priorities upon termination of the plan; information concerning whether or not a tax ruling or determination letter has been obtained; and any other matters necessary to fully and fairly present the financial statements of such pension plan.

(3) With respect to all employee benefit plans, the statement required under paragraph (1) or (2) shall have attached the following information in separate schedules:

(A) a statement of the assets and liabilities of the plan aggregated by categories and valued at their current value, and the same data displayed in comparative form for the end of the previous fiscal year of the plan;

(B) a statement of receipts and disbursements during the preceding twelve-month period aggregated by general sources and applications;

(C) a schedule of all assets held for investment purposes aggregated and identified by issuer, borrower, or lessor, or similar party to the transaction (including a notation as to whether such party is known to be a party in interest), maturity date, rate of interest, collateral, par or maturity value, cost, and current value;

(D) a schedule of each transaction involving a person known to be party in interest, the identity of such party in interest and his relationship or that of any other party in interest to

the plan, a description of each asset to which the transaction relates; the purchase or selling price in case of a sale or purchase, the rental in case of a lease, or the interest rate and maturity date in case of a loan; expenses incurred in connection with the transaction; the cost of the asset, the current value of the asset, and the net gain (or loss) on each transaction;

(E) a schedule of all loans or fixed income obligations which were in default as of the close of the plan's fiscal year or were classified during the year as uncollectable and the following information with respect to each loan on such schedule (including a notation as to whether parties involved are known to be parties in interest): the original principal amount of the loan, the amount of principal and interest received during the reporting year, the unpaid balance, the identity and address of the obligor, a detailed description of the loan (including date of making and maturity, interest rate, the type and value of collateral, and other material terms), the amount of principal and interest overdue (if any) and an explanation thereof;

(F) a list of all leases which were in default or were classified during the year as uncollectable; and the following information with respect to each lease on such schedule (including a notation as to whether parties involved are known to be parties in interest): the type of property leased (and, in the case of fixed assets such as land, buildings, leasehold, and so forth, the location of the property), the identity of the lessor or lessee from or to whom the plan is leasing, the relationship of such lessors and lessees, if any, to the plan, the employer, employee organization, or any other party in interest, the terms of the lease regarding rent, taxes, insurance, repairs, expenses, and renewal options; the date the leased property was purchased and

its cost, the date the property was leased and its approximate value at such date, the gross rental receipts during the reporting period, expenses paid for the leased property during the reporting period, the net receipts from the lease, the amounts in arrears, and a statement as to what steps have been taken to collect amounts due or otherwise remedy the default;

(G) if some or all of the assets of a plan or plans are held in a common or collective trust maintained by a bank or similar institution or in a separate account maintained by an insurance carrier or a separate trust maintained by a bank as trustee, the report shall include the most recent annual statement of assets and liabilities of such common or collective trust, and in the case of a separate account or a separate trust, such other information as is required by the administrator in order to comply with this subsection; and

(H) a schedule of each reportable transaction, the name of each party to the transaction (except that, in the case of an acquisition or sale of a security on the market, the report need not identify the person from whom the security was acquired or to whom it was sold) and a description of each asset to which the transaction applies; the purchase or selling price in case of a sale or purchase, the rental in case of a lease, or the interest rate and maturity date in case of a loan; expenses incurred in connection with the transaction; the cost of the asset, the current value of the asset, and the net gain (or loss) on each transaction. For purposes of the preceding sentence, the term "reportable transaction" means a transaction to which the plan is a party if such transaction is –

(i) a transaction involving an amount in excess of 3 percent of the current value of the assets of the plan;

(ii) any transaction (other than a transaction respecting a security) which is part of a series of transactions with or in conjunction with a person in a plan year, if the aggregate amount of such transactions exceeds 3 percent of the current value of the assets of the plan;

(iii) a transaction which is part of a series of transactions respecting one or more securities of the same issuer, if the aggregate amount of such transactions in the plan year exceeds 3 percent of the current value of the assets of the plan; or

(iv) a transaction with or in conjunction with a person respecting a security, if any other transaction with or in conjunction with such person in the plan year respecting a security is required to be reported by reason of clause (i).

(4) The Secretary may, by regulation, relieve any plan from filing a copy of a statement of assets and liabilities (or other information) described in paragraph (3)(G) if such statement and other information is filed with the Secretary by the bank or insurance carrier which maintains the common or collective trust or separate account.

**(c) Information to be furnished by administrator**

The administrator shall furnish as a part of a report under this section the following information:

(1) The number of employees covered by the plan.

(2) the name and address of each fiduciary.

(3) Except in the case of a person whose compensation is minimal (determined under regulations of the Secretary) and who performs solely ministerial duties (determined under such regulations), the name of each person (including but not limited to, any consultant, broker, trustee, accountant, insurance carrier, actuary, administrator, investment manager, or custodian who rendered services to the plan or who had transactions with the plan) who received directly or indirectly compensation from the plan during the preceding year for services rendered to the plan or its participants, the amount of such compensation, the nature of his services to the plan or its participants, his relationship to the employer of the employees covered by the plan, or the employee organization, and any other office, position, or employment he holds with any party in interest.

(4) An explanation of the reason for any change in appointment of trustee, accountant, insurance carrier, enrolled actuary, administrator, investment manager, or custodian.

(5) Such financial and actuarial information including but not limited to the material described in subsections (b) and (d) of this section as the Secretary may find necessary or appropriate.

**(d) Actuarial statement**

With respect to an employee pension benefit plan (other than (A) a profit sharing, savings, or other plan, which is an individual account plan, (B) a plan described

in section 1081(b) of this title, or (C) a plan described both in section 1321(b) of this title and in paragraph (1), (2), (3), (4), (5), (6), or (7) of section 1081(a) of this title) an annual report under this section for a plan year shall include a complete actuarial statement applicable to the plan year which shall include the following:

(1) The date of the plan year, and the date of the actuarial valuation applicable to the plan year for which the report is filed.

(2) The date and amount of the contribution (or contributions) received by the plan for the plan year for which the report is filed and contributions for prior plan years not previously reported.

(3) The following information applicable to the plan year for which the report is filed: the normal costs, the accrued liabilities, an identification of benefits not included in the calculation; a statement of the other facts and actuarial assumptions and methods used to determine costs, and a justification for any change in actuarial assumptions or cost methods; and the minimum contribution required under section 1082 of this title.

(4) the number of participants and beneficiaries, both retired and nonretired, covered by the plan.

(5) The current value of the assets accumulated in the plan, and the present value of the assets of the plan used by the actuary in any computation of the amount of contributions to the plan required under section 1082 of this title and a statement explaining the basis of such valuation of present value of assets.

(6) The present value of all of the plan's liabilities for nonforfeitable pension benefits

allocated by the termination priority categories as set forth in section 1344 of this title, and the actuarial assumptions used in these computations. The Secretary shall establish regulations defining (for purposes of this section) "termination priority categories" and acceptable methods, including approximate methods, for allocating the plan's liabilities to such termination priority categories.

(7) A certification of the contribution necessary to reduce the accumulated funding deficiency to zero.

(8) A statement by the enrolled actuary –

(A) that to the best of his knowledge the report is complete and accurate, and

(B) the requirements of section 1082(c)(3) of this title (relating to reasonable actuarial assumptions and methods) have been complied with.

(9) A copy of the opinion required by subsection (a)(4) of this section.

(10) A statement by the actuary which discloses –

(A) any event which the actuary has not taken into account, and

(B) any trend which, for purposes of the actuarial assumptions used, was not assumed to continue in the future,

but only if, to the best of the actuary's knowledge, such event or trend may require a material increase in plan costs or required contribution rates.

(11) Such other information regarding the plan as the Secretary may by regulation require.

(12) Such other information as may be necessary to fully and fairly disclose the actuarial position of the plan.

Such actuary shall make an actuarial valuation of the plan for every third plan year, unless he determines that a more frequent valuation is necessary to support his opinion under subsection (a)(4) of this section.

**(e) Statement from insurance company, insurance service, or other similar organizations which sell or guarantee plan benefits**

If some or all of the benefits under the plan are purchased from and guaranteed by an insurance company, insurance service, or other similar organization, a report under this section shall include a statement from such insurance company, service, or other similar organization covering the plan year and enumerating –

(1) the premium rate or subscription charge and the total premium or subscription charges paid to each such carrier, insurance service, or other similar organization and the approximate number of persons covered by each class of such benefits; and

(2) the total amount of premiums received, the approximate number of persons covered by each class of benefits, and the total claims paid by such company, service, or other organization; dividends or retroactive rate adjustments, commissions, and administrative service or other fees or other specific acquisition costs paid by such company, service, or other organization; any amounts held to provide benefits after retirement; the remainder of such premiums; and the names and addresses of the brokers, agents, or other persons to whom commissions

or fees were paid, the amount paid to each, and for what purpose. If any such company, service, or other organization does not maintain separate experience records covering the specific groups it serves, the report shall include in lieu of the information required by the foregoing provisions of this paragraph (A) a statement as to the basis of its premium rate or subscription charge, the total amount of premiums or subscription charges received from the plan, and a copy of the financial report of the company, service, or other organization and (B) if such company, service, or organization incurs specific costs in connection with the acquisition or retention of any particular plan or plans, a detailed statement of such costs.

(Pub.L. 93-406, Title I, § 103, Sept. 2, 1974, 88 Stat. 841; Pub.L. 96-364, Title III, § 307, Sept. 26, 1980, 94 Stat. 1295.)

(2)

No. 90-640

In The

# Supreme Court of the United States

October Term, 1990

MARY JANE WICKMAN,

*Petitioner,*

v.

NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY,

*Respondent.*

## BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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## QUESTIONS PRESENTED FOR REVIEW

1. Whether petitioner's claim is governed by the Employee Retirement Income Security Act (ERISA) (29 U.S.C. §1001 et seq.)?

2. Whether the Court of Appeals misinterpreted federal common law under ERISA in affirming the District Court's conclusion that petitioner failed to carry her burden of proving that her husband's death was accidental?

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MISCELLANEOUS

## STATEMENT OF THE CASE

This action was commenced in the District Court for the District of Massachusetts by petitioner Mary Jane Wickman ("petitioner" or "Mrs. Wickman") seeking to recover the accidental death benefit under a group policy of insurance issued by respondent Northwestern National Life Insurance Company ("Northwestern") (Pet. App. A at 2a; Pet. App. B at 1b)[1]. The group policy covered Mrs. Wickman's late husband, Paul Wickman ("Mr. Wickman"), who died on July 11, 1984 (Pet. App. A at 2a, 4a). Originally commenced in federal court as a common law contract claim based on diversity of citizenship, the case was dismissed and the complaint amended so as to state a claim for benefits under section 1332 of the Employee Retirement Income Security Act (ERISA) (Pet. App. A at 7a). The parties agreed that there was no right to a jury trial in a claim for benefits under ERISA and consented to a trial before Magistrate Collings (Petition at 7; Pet. App. A at 7a).

After a four-day trial, where the evidence was considered on a *de novo* basis, the Magistrate concluded that Mrs. Wickman had not carried her burden of proving that Mr. Wickman's death was accidental (Pet. App. A at 7a; Pet. App. B at 5b, 12b-13b). Therefore, she was not entitled to recover accidental death benefits under Northwestern's group policy (Pet. App. B at 13b).

Mrs. Wickman appealed to the Court of Appeals for the First Circuit and challenged the Magistrate's ruling

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[1] References to "Pet. App." and "Resp. App." are to Petitioner's Appendix and Respondent's Appendix, respectively.

that her claim was governed by ERISA and his ultimate ruling that she had failed to prove that her husband's death was an accident so as to entitle her to benefits (Pet. App. A at 7a). The Court of Appeals, in a detailed and well-reasoned opinion, affirmed the Magistrate's rulings, holding that 1) Northwestern's group insurance benefits were part of an employee benefit plan provided by Mr. Wickman's employer and therefore were governed by ERISA (Pet. App. A at 11a-12a), and 2) the Magistrate applied a correct legal standard to the facts found in reaching his conclusion that Mr. Wickman's death was not an accident (Pet. App. A at 25a-27a). The former holding with respect to the applicability of ERISA was based primarily on the fact that Mr. Wickman's employer, Dexter Corporation, had provided its employees with a comprehensive benefit program, part of which was accidental death insurance, all as evidenced by Plaintiff's Exhibit 17, which clearly constituted an employee benefit plan under ERISA (Pet. App. A at 11a-12a; Resp. App. A). The Court of Appeals' holding with respect to the non-accidental character of Mr. Wickman's death was based on what the court determined to be the federal common law under ERISA with respect to accidental death insurance benefits (Pet. App. A at 13a). Applying this federal common law standard to the Magistrate's findings and rulings, the court concluded that the Magistrate did not commit any error of law in ruling that Mr. Wickman's death was not an accident in light of the facts found, which were not seriously disputed (Pet. App. A at 27a).

## ARGUMENT

### 1. The District Court And Court Of Appeals Were Correct In Finding The Existence Of An ERISA Plan (Petition at 10-17).

As the Court of Appeals correctly stated, the question of whether an ERISA plan exists is "a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person" (Pet. App. A at 8a-9a, quoting from *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988), cert. denied, ___ U.S. ___, 109 S. Ct. 3216 (1989)). Both the Magistrate in the District Court and the Court of Appeals made detailed findings and well-reasoned rulings in reaching the conclusion that Mr. Wickman's employer had established an "employee welfare benefit plan" as defined by ERISA and therefore petitioner's claim for accidental death benefits under the plan was governed by ERISA (Pet. App. A at 8a-12a, Pet. App. C). Both the District Court and the Court of Appeals followed the analysis on this issue first developed in *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) (en banc), and which continues to have widespread acceptance. See, *Hughes v. Blue Cross of No. California*, 215 Cal. App.3d 832, 854, 263 Cal. Rptr. 850, 863 (Cal. App. 1989), cert. denied, ___ U.S. ___, 110 S. Ct. 2200 (1990) ("*Donovan* adopted an analysis of the statutory language that enjoys widespread acceptance"). Their findings of fact are fully supported by the record, and most certainly are not clearly erroneous, and their conclusions are unassailable as a matter of law.

Petitioner's entire argument appears to be based on the premise that the mere purchase of group insurance by

an employer, and the annual payment of premiums thereon, is insufficient to establish an ERISA plan. Unfortunately, such a premise has nothing to do with the true facts of this case as established by the record. Most importantly, this premise totally disregards the fact that Mr. Wickman's employer, The Dexter Corporation, established a comprehensive benefit program for all its employees, of which the Northwestern National accidental death and dismemberment benefits (AD&D) were only one small part. As the Court of Appeals noted (Pet. App. A at 11a-12a), Dexter Corporation's purchase of this insurance was not an isolated incident but was part of a comprehensive benefit program as established by petitioner's own trial exhibit 17 (Resp. App. A attached)[2]. Petitioner's trial exhibit 17 (Resp. App. A), entitled "STATEMENT OF BENEFITS AND POLICIES" and prepared by The Dexter Corporation (Resp. App. A at 1a), contains a detailed description of all the benefits available to employees of The Dexter Corporation, including pension, insurance, profit-sharing, tuition assistance and savings plans (Resp. App. A at 21a-23a). Various types of insurance, including life, medical, dental and short and long term disability, were provided under the plan (Resp. App. A at 1a-10a). A "Summary Plan Description" of Northwestern's plan of insurance, including a "Statement of ERISA Rights" and a description of "Claim Procedures", all as required by 29 U.S.C. §1022, was included in the document (Resp. App. A at 17a-21a). Mr. Wickman,

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[2] Respondent's Appendix A includes only certain material sections of petitioner's trial exhibit 17. The complete document, which was introduced at trial, consists of 96 pages.

as a participant, was advised that this particular "plan of benefits" was administered by the Hysol Division of The Dexter Corporation (Resp. App. A at 17a) and that all claims for benefits would be processed by Northwestern (Resp. App. A at 18a). Mr. Wickman was further advised that he was "entitled to certain rights and protections under the Employee Retirement Security Act of 1974 (ERISA)" and he was then given a detailed description of those rights (Resp. App. A at 19a-21a). The "Claims Procedures" in the Summary Plan Description specifically set forth how a claim was to be filed and, if denied, how it could be appealed (Resp. App. A at 18a-19a). As the Court of Appeals indicated, this benefit program, of which Northwestern's accidental death insurance was a part, clearly showed that Dexter Corporation did more than simply purchase a group insurance policy and remit annual premiums (Pet. App. A at 11a-12a), as contended by petitioner.

This extensive benefit plan renders moot petitioner's contentions that there was little or no administrative responsibility on the part of the employer, Dexter Corporation, and therefore the safeguards of ERISA should not be invoked (Petition at 11-13). It also shows that petitioner's statements that "Northwestern never produced the written instrument required by 29 U.S.C. §1102 for creation of an "employer benefit plan" (Petition at 7-8) and "It is impossible to tell from the record whether or not Northwestern's insurance policy is even a part of an "employee welfare benefit plan" (Petition at 8) are patently false. In fact, these statements are directly contrary to statements made by petitioner in her Reply Brief to the

Court of Appeals. In her Reply Brief[3], petitioner unequivocally stated that "A review of Ex. 17 ["STATEMENT OF BENEFITS AND POLICIES"] *indicates that the Dexter Corporation did establish an ERISA plan;*" (Resp. App. B at 3b) (emphasis added), but went on to mistakenly conclude that "however, the life insurance policy purchased from Northwestern was not part of it" (Resp. App. B at 3b). While the specific page reference to the life insurance section of the plan was incorrect, as pointed out by petitioner, the fact remains that the Northwestern accidental death benefit was in fact a part of Dexter Corporation's benefit plan (Resp. App. A at 2a-7a, 17a-21a). Petitioner went on in her Reply Brief to concede that the Dexter plan "set forth a right of review, as is required by ERISA", citing 29 CFR §2560.503-1(g), with respect to the medical and dental benefits (Resp. App. B at 3b). Since the "right of review" with respect to Northwestern's life insurance (Resp. App. A at 18a-19a) is identical to the "right of review" with respect to medical and dental benefits (Resp. App. A at 13a-15a), petitioner would undoubtedly concede that the life insurance right of review also satisfies the procedural requirements of ERISA.

Since petitioner's entire argument on the non-applicability of ERISA is premised on a factually incorrect assumption, i.e. that the only evidence of Dexter Corporation's "plan" was the mere purchase of a group insurance policy, the entire argument is flawed. For the same reason, petitioner's reliance on *Fort Halifax Packing Co. v.*

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[3] Respondent's Appendix B consists of 3 pages from Petitioner's Reply Brief which are pertinent to the point under discussion.

*Coyne*, 482 U.S. 1, 107 S. Ct. 2211 (1987) is misplaced. In addition, the *Fort Halifax* case is distinguishable, as pointed out by the Magistrate (Pet. App. C at 10c-12c), in light of Justice Brennan's footnote 9 in which he contrasted the one-time severance payment mandated by Maine's statute to life insurance benefits paid to deceased employees' survivors on an ongoing basis. 107 S. Ct. at 2219. He noted that the latter situation requires an administrative scheme to process claims and pay out benefits, while the former situation did not since there were no ongoing benefits to be paid. *Id.* Thus, the *Fort Halifax* case supports the concept which was assumed in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549 (1987), that a group insurance policy issued to an employer, on which premiums are at least partially paid by the employer, can constitute the basis of an employee benefit plan under ERISA.

Petitioner appears to place great importance on certain evidence at trial from Northwestern's claim representative that she did not understand she was acting as a fiduciary and did not realize that petitioner's claim might be governed by ERISA (Petition at 7, 13-14). The Court of Appeals attached no significance to this and rightfully so. Whether Northwestern acted properly as a fiduciary or whether it complied with the administrative requirements of ERISA are irrelevant to the fundamental question of whether an employee benefit plan exists at all. This latter determination is made simply by applying the definition of "employee welfare benefit plan" in 29 U.S.C. §1002(1) to the facts of a particular case. *Donovan v.*

*Dillingham, supra,* 688 F.2d at 1370-1373. Once it is determined that ERISA applies to a "plan" because the statutory definition has been satisfied, the "Regulatory Provisions" in Subtitle B of ERISA, including "Reporting and Disclosure" (§§1021-1031), "Participation and Vesting" (§§1051-1061), "Funding" (§§1081-1086), "Fiduciary Responsibility" (§§1101-1114) and "Administration and Enforcement" (§§1131-1145), come into play. *Id.* at 1372. However, as the *Donovan* court stated, "clearly these are only the responsibilities of administrators and fiduciaries of plans covered by ERISA and *are not prerequisites to coverage under the Act" Id.* (emphasis added). ERISA coverage applies regardless of whether these several administrative responsibilities have been met. *Id. Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546, 551 (6th Cir. 1989), citing *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352, 1355 (9th Cir. 1984), cert. denied, 474 U.S. 865 (1985). See also, *Scott v. Gulf Oil Co.*, 754 F.2d 1499, 1503 (9th Cir. 1985). Thus, in the instant case, whether there was a written instrument as required by 29 U.S.C. §1102, or whether there was compliance with 29 U.S.C. §1133 (Petition at 7-8), or whether Northwestern acted properly as a fiduciary as required by 29 U.S.C. §1104 (Petition at 13-14), are entirely irrelevant to the question of whether an ERISA plan exists in the first instance.

Petitioner's contentions with respect to the applicability of ERISA to this case have been fully considered and correctly decided by both the District Court and the Court of Appeals. There are clearly no special or important reasons, nor any split of authorities, which would justify granting a writ of certiorari to further consider these contentions.

**2. The Court Of Appeals Did Not Create A Never-Never-Land Between Suicide And Accident (Petition at 18-21).**

Neither the Magistrate nor the Court of Appeals left any doubt that their ultimate finding in the case was that Mr. Wickman's death was not the result of an accident. Since this finding was entirely determinative of Mrs. Wickman's claim for *accidental death* benefits, there was obviously no need to go any further and make additional findings with respect to the issue of suicide. Thus, the petitioner is completely in error when she argues that some "Never-Never Land" was created.

The Magistrate specifically found that "the plaintiff has not carried her burden, i.e. demonstrated by a preponderance of the evidence that Mr. Wickman's death was accidental within the meaning of the insurance policy" (Pet. App. B at 5b; also see Pet. App. B at 11b, 13b). The Court of Appeals affirmed this ruling, holding that "we believe that the magistrate did not err in ruling that Wickman's death was not an accident within the terms of the insurance policy" (Pet. App. A at 25a). The Court of Appeals went on in a footnote to dispose of petitioner's present contention: "Because the magistrate decided there was no accident in this case, and we affirm on this basis, he did not and we need not reach the question of whether Wickman's death was actually a suicide" (Pet. App. A at 25a, n. 5). The rulings of both the Magistrate and the Court of Appeals on this point couldn't be any clearer or any more determinative of petitioner's claim.

**3. In Raising The Presumption Against Suicide And The Prima Facie Effect Of The Death Certificate, Petitioner Is Arguing The Weight Of The Evidence (Petition at 22-26).**

Since this case was tried to the Magistrate without a jury (Pet. App. B at 2b, 14b), the Magistrate's findings must be accepted unless clearly erroneous. Fed. R. Civ. P. 52(a). Petitioner is not directly challenging the Magistrate's findings as clearly erroneous, but she is challenging them indirectly by arguing that some weight, or greater weight, should have been accorded the presumption against suicide and the prima facie effect of Mr. Wickman's death certificate. Petitioner argues that these presumptions should both have been operative in this case with the result that she presented a prima facie case of accidental death (Petition at 25). However, such a contention is meaningless in light of the fact that there was abundant, real evidence, not presumptions, from several live witnesses who had personal knowledge of the facts and circumstances surrounding Mr. Wickman's death (Pet. App. A at 2a-5a; Pet. App. B at 7b-9b). Obviously, the Magistrate had no need to resort to evidentiary presumptions since there was clear and convincing real evidence on the issue of accident. Moreover, the presumption against suicide is merely a rebuttable presumption of fact which stands until rebutted by other evidence. *Bohaker v. Travelers Insurance Co.*, 215 Mass. 32, 36, 102 N.E. 342, 344 (1913). Under Massachusetts law, which petitioner concedes is the law applicable to these presumptions (Petition at 22), the presumption against suicide disappears once contrary evidence is introduced. Liacos, Handbook of Massachusetts Evidence, 54 (1981).

The cases cited by petitioner on this issue from other jurisdictions are not controlling because in those cases the presumption against suicide had the weight of affirmative evidence and the presumption did not disappear once contrary evidence was presented. *Dick v. New York Life Ins. Co.*, 359 U.S. 437, 442-444, 79 S. Ct. 921, 925 (1959) (applying North Dakota law). *Canada Life Assurance Co. v. Houston*, 241 F.2d 523, 531-532 (9th Cir. 1957) (applying California law). This is simply not the law on presumptions in Massachusetts.

Furthermore, the "prima facie" effect of the "facts recorded" in the amended death certificate – "Massive internal hemorrhage secondary to fracture – dislocation of pelvis – caused by 90 foot fall from bridge" (Petition at 23-24) – is inconclusive on the issue of whether death was accidental. There is nothing in the death certificate stating whether death was accidental or not, and the foregoing statement of facts as to the *cause* of the death leaves it entirely to conjecture as to whether the *manner* of death was accidental. Again, the Magistrate obviously felt no need to resort to such inconclusive information when there was real evidence which was much more helpful on the issue of whether death was accidental.

The bottom line is that petitioner is indirectly contending that the Magistrate's factual findings are wrong (she never uses the phrase "clearly erroneous") because he didn't place greater weight on the foregoing presumptions. Not only does this contention employ an improper standard for reviewing factual findings of a lower court, it is a contention which has no place under this Court's standards of review on a petition for certiorari. Rules of the Supreme Court, Rule 10.

**4. The Court Of Appeals Test For Considering Accidental Death Cases Under ERISA Federal Common Law Is Legally Sound And In Accordance With Common Law Precedents (Petition at 18-21, 26-29).**

Contrary to petitioner's contentions, the Court of Appeals approach to analyzing accidental death cases such as this will not "plunge the federal common law into a 'Serbonian bog' " (Petition at 29). Nor will application of this approach result in the denial of millions of dollars in accidental death benefits (Petition at 18). Such contentions evidence a complete lack of understanding by petitioner of the test formulated by the Court of Appeals. Quite to the contrary, this test provides a practical and easily applied formula for the factfinder to use which is fully supported by the many state and federal common law cases which have struggled with the concept of accidental death.

The Court of Appeals correctly rejected the outdated distinction between "accidental means" and "accidental results" as being artificial and confusing[4] (Pet. App. A at 17a-20a). After concluding that definitions of the term "accident" are not helpful, since the term is largely intuitive (Pet. App. A at 20a-21a), the Court went on to devise the following analysis for use in accidental death cases. The factfinder must first determine whether the result which occurred was within the "reasonable expectations

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[4] Northwestern has always accepted the policy language as creating "accidental results" coverage rather than "accidental means" coverage. The Magistrate's opinion clearly shows that he did not use, nor even consider, an "accidental means" standard in analyzing the case (Pet. App. B at 9b-10b).

of the insured." If it was, then there can be no accident. If it wasn't, then the factfinder must consider whether the insured's reasonable expectations were "patently unreasonable." If they were, as in the case of "Russian roulette", then again there can be no accident. If the factfinder is unable to determine the subjective expectations of the insured, then it should consider the objective expectations of a "reasonable person" standing in the shoes of the insured. The core concepts of this analysis are that the issue of accidental death is almost always one of fact and the determination is to be made from the subjective perspective of the insured.

None of the cases cited by petitioner are inconsistent with the foregoing formula. In fact, mostly all of them endorse, although in somewhat different terms, the approach promulgated by the Court of Appeals. For example, in *Collins v. Nationwide Life Ins. Co.*, 294 N.W.2d 194 (Mich. 1980) (Petition at 26-27), the Michigan Supreme Court expressly endorsed the concept of the insured's foreseeable expectations as the appropriate standard and rejected the use of the tort concept of reasonable foreseeability. *Id.* at 196. (Insured died from acute alcoholic intoxication). In *Catania v. State Farm Life Ins. Co.*, 598 P.2d 631 (Nev. 1979) (Petition at 27), the Nevada Supreme Court adopted the reasoning of *Knight v. Metropolitan Life Ins. Co.*, 103 Ariz. 100, 437 P.2d 416 (1968) and *Miller v. Continental Ins. Co.*, 40 N.Y.2d 675, 389 N.Y.S.2d 565, 358 N.E.2d 258 (1976) in approaching the issue from the point of view of the insured, not the "reasonable man", and whether from the insured's point of view the result was "unexpected, unusual and unforeseen." *Miller* case, *supra*, 40 N.Y.2d at 677. To the same effect are

*Kearbey v. Reliable Life Ins. Co.*, 526 S.W.2d 866 (Mo. App. 1975) (Petition at 27-28), *Sivley v. American National Ins. Co.*, 454 S.W.2d 799 (Tex. App. 1970) (Petition at 29) and *Russell v. Metropolitan Life Ins. Co.*, 439 N.E.2d 89 (Ill. App. 1982) (Petition at 29), all of which adopt a subjective test of foreseeability. There is no doubt that the results in all of these cases would have been the same if the Court of Appeals approach had been used.

The Court of Appeals approach is not at all different from the prevailing common law approach, see 10 Couch on Insurance 2d, §41:7 at 9 ("An accident [is anything] . . . that takes place without the insured's foresight or expectation . . . . "), and §§41:15, 41:17, 41:23, 41:25; 1A Appleman, Insurance Law and Practice, §360 (at 452-453: "In construing whether or not a certain result is accidental, it is customary to look at the casualty from the point of view of the insured, to see whether or not, from his point of view, it was unexpected, unusual and unforeseen."). It merely clarifies the application of this approach in accidental death cases. For example, the Court's requirement that the insured's expectations not be "patently unreasonable" (Pet. App. A at 22a-24a) in order for the death to be accidental is entirely consistent with the results reached in Russian roulette cases and autoerotic asphyxiation cases (Pet. App. A at 22a-23a; Pet. App. B at 13b). In each of these types of cases, courts generally conclude that the insured's expectation that he will not die as a result of his voluntary conduct is so patently unreasonable that the resulting death cannot be deemed an accident. See, *Nicholas v. Provident Life & Acc. Ins. Co.*, 61 Tenn. App. 633, 457 S.W.2d 536 (1970) (Russian roulette) and *Runge v. Metropolitan Life Ins. Co.*, 537 F.2d 1157

(4th Cir. 1976) (autoerotic asphyxiation). *But see, Kennedy v. Washington National Ins. Co.*, 401 N.W.2d 842 (Wis. App. 1987) (Death from autoerotic asphyxiation is not highly probable or likely to occur and therefore differs from Russian roulette). On the other hand, an insured's death from an overdose of drugs or alcohol is generally considered to be accidental because death as a result of taking drugs is not deemed to be "highly probable". See, *Hardy v. Beneficial Life Ins. Co.*, 787 P.2d 1 (Utah App. 1990) (Defendant failed to establish the "high level of certainty" that death or injury would result from insured's consumption of drugs).

As the Court of Appeals noted (Pet. App. A at 26a-27a), the Magistrate specifically found that Mr. Wickman's actions in climbing over the guardrail and hanging by one hand were intentional and knowing and that it was reasonably foreseeable to him that death or serious bodily injury was substantially likely to occur (Pet. App. B at 11b, 12b-13b). Under any test or formulation that has yet been articulated, these factual findings mandate the conclusion that Mr. Wickman's resulting death was not accidental. The Magistrate further found that, unlike the numerous cases cited by petitioner (Petition at 26-29), "[T]his is not a case wherein the insured intentionally did an act with some unexpected result" (Pet. App. B at 11b). Thus, the several cases cited by petitioner, most of which involve death as a result of an overdose of drugs or alcohol, are inapposite. Again, with these underlying factual findings of Mr. Wickman's intent and knowledge, no other conclusion could be reached than that Mr. Wickman's death was not accidental.

## CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

NORTHWESTERN NATIONAL LIFE
INSURANCE COMPANY
By their attorneys,
EDWARD S. ROONEY, Jr.*
LYNE, WOODWORTH & EVARTS
75 Federal Street
Boston, MA 02110
(617) 482-6655
**Counsel of Record*

DEXTER LOGO

# HYSOL DIVISION
# THE DEXTER CORPORATION

# STATEMENT
# OF
# BENEFITS & POLICIES

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DENTAL COVERAGE



* * *

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LIFE INSURANCE

**Northwestern National Life Insurance Company**
**Minneapolis, Minnesota 55440**

We, Northwestern National Life Insurance Company, certify that we have issued the Group Policy(ies) listed below to the Policyholder. All benefits are controlled by the terms and conditions of the Group Policy(ies).

The Group Policy(ies) are on file in the Policyholder's office. You may look at the Group Policy(ies) there.

| Group Policy Number | Policyholder |
|---|---|
| GL-18090-4 | The Dexter Corporation |

Your beneficiary is the last beneficiary you named, according to the records on file in our Home Office. You may change your beneficiary any time, according to the terms of the Group Policy.

The Policyholder must provide to you a 15 day written notice if and when the Group Policy is cancelled or substituted.

This certificate summarizes and explains the parts of the Group Policy which apply to you. This certificate is not an insurance policy. In any cases of differences or errors, the Group Policy rules.

This certificate replaces any other certificates we may have given you under the Group Policy.

/s/ Gretchen A. Larson
Registrar

## LIFE INSURANCE

**Schedule of Benefits**

**BASIC LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE**

| Class | Amount of Life Insurance | Full Amount of AD&D Insurance |
|---|---|---|
| Exempt employees whose Basic Yearly Earnings* are ___ | | |
| $10,000 but less than $12,500 | $15,000 | $15,000 |
| $12,500 but less than $15,000 | $17,500 | $17,500 |
| $15,000 but less than $17,500 | $20,000 | $20,000 |
| $17,500 but less than $20,000 | $22,500 | $22,500 |
| $20,000 but less than $22,500 | $25,000 | $25,000 |
| $22,500 but less than $25,000 | $30,000 | $30,000 |
| $25,000 but less than $27,500 | $35,000 | $35,000 |
| $27,500 but less than $30,000 | $40,000 | $40,000 |
| $30,000 but less than $32,500 | $45,000 | $45,000 |
| $32,500 but less than $35,000 | $50,000 | $50,000 |
| $35,000 but less than $40,000 | $55,000 | $55,000 |
| $40,000 but less than $45,000 | $65,000 | $65,000 |
| $45,000 but less than $50,000 | $75,000 | $75,000 |
| $50,000 but less than $55,000 | $85,000 | $85,000 |
| $55,000 but less than $60,000 | $95,000 | $95,000 |
| $60,000 and over | $105,000 | $105,000 |
| Retired exempt employees | $2,500 | none |

* * *

## LIFE INSURANCE

### AD&D Insurance

**What is the Accidental Death and Dismemberment (AD&D) Insurance Benefit?**

We pay AD&D benefits if you lose your life, limb, or sight due to accidental injury.

**Under what conditions do we pay benefits?**

We pay benefits if all of the following are true:

- You are covered for AD&D Insurance on the date of the accident.
- Loss occurs within 180 days of the accident.
- The cause of the loss is not excluded.

**How much will we pay?**

We pay the benefit shown on the Table of AD&D Benefits if you suffer any of the losses listed. The Full Amount of AD&D Insurance is shown in the Schedule of Benefits. We pay only one Full Amount for any one accident.

**Table of AD&D Benefits**

| For loss of: | The benefit is: |
|---|---|
| Life | Full Amount |
| Both hands | Full Amount |
| Both feet | Full Amount |
| Sight of both eyes | Full Amount |
| 1 hand and 1 foot | Full Amount |
| 1 hand and sight of 1 eye | Full Amount |
| 1 foot and sight of 1 eye | Full Amount |
| 1 hand | 1/2 Full Amount |
| 1 foot | 1/2 Full Amount |
| Sight of 1 eye | 1/2 Full Amount |

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight.

We do not pay a benefit for loss of use of the hand or foot.

**To whom do we pay benefits?**

We pay death benefits to your beneficiary. We pay any other benefits to you.

**When don't we pay benefits?**

We do not pay benefits for loss directly or indirectly caused by any of these:

- Suicide or intentionally self-inflicted injury, whether you are sane or insane.
- Physical or mental illness.
- Bacterial infection or poisoning. **Exception:** Infection from a cut or wound caused by an accident is covered.
- Riding in or descending from an aircraft as a pilot or crew member.
- An act of war.
- Injury suffered while in the military service for any country.

  **"War"** is any armed conflict, whether declared as war or not, involving a country. **"Country"** is any government or group of countries. **"Military service"** means service in any army, navy, air force, marines, coast guard, or any branch of the military.
- Injury which occurs during a crime you commit or try to commit.

**How do you submit a claim?**

**Step. 1.**

Written notice of claim must be sent to us within 20 days of your death or dismemberment, or as soon as possible. We will send you forms for filing proof of loss within 15 days after receiving the notice of claim.

**Step. 2.**

Written proof of loss must be sent to us within 90 days of your death or dismemberment, or as soon as possible. Written proof includes details about the loss and how it happened. Proof of loss must be sent in the required time even if proof of loss forms are not received.

We may, at our expense, require an exam while considering your claim. If you die, we may require an autopsy where law permits.

* * *

## INTRODUCTION

If you are ill or injured and cannot work for a short period of time, it's comforting to know that the Hysol Division provides benefits to protect you against loss of income. These temporary disability benefits are provided under the Short Term Disability Income Benefits Plan. Your benefits begin as soon as you are disabled and pay you up to 100% of your base salary for up to six months, depending upon your length of service.

The full cost of these temporary disability benefits is paid for by the Company.

The remainder of this summary explains your temporary disability benefits in more detail.

## SHORT TERM DISABILITY INCOME BENEFITS

If your non-work-related illness or injury takes you away from work, you will be eligible for Short Term Disability (STD) Income Benefits. Workers' Compensation will cover work-related illness or injury.

As soon as you are disabled, you will begin receiving Company benefits. The table below outlines those benefits, based on your length of service.

| IF you have . . . | THEN you will receive . . . | FOR . . . |
|---|---|---|
| less that 1 year of continuous service | 50% of your base salary | up to 6 months |
| 1-6 years of continuous service | 1) 1 month's full base salary for each year of continuous service, **then** 2) 50% of your base salary for the remaining months | up to 6 months |
| more than 6 years of continuous service | your full monthly base salary | the first 6 months of your disability |

For example, if you

- have worked 4 years,
- earn a monthly salary of $1,500, and
- are disabled for 5 months

. . . you will receive total benefits of $6,750: (4 months x $1,500/month + (1 month x $1,500/month x .5) = $6,750.

In order to receive the STD benefits, you may be asked to show medical proof of disability (e.g. doctor's written statement) in order for benefits to be paid or continued.

* * *

**Who Is Eligible**

As a full-time employee, working at least 30 hours per week, you automatically participate in the Long Term Disability (LTD) Insurance Plan, providing:

- you have completed 12 months of continuous employment, and
- you have not reached the age of 69 years and 6 months

## COST

The Company pays the full cost of your LTD coverage.

## SUMMARY OF BENEFITS

If you become totally disabled as a result of an illness, injury or pregnancy for at least six consecutive months, LTD benefits will provide monthly income to you.

**Amount of Monthly Benefit**

Your monthly benefit is the Schedule Amount reduced by the Offset Amount. In no event will your monthly benefit exceed the Monthly Payment Limit.

The Schedule Amount is an amount equal to

- 50% of your monthly earnings

  up to a

- maximum schedule amount of $3,500.

The Offset Amount consists of the following payments and benefits for your disability from the following sources. These payments and benefits are subtracted directly from the schedule amount of benefit.

- retirement benefits provided under any formal or informal plan or arrangement contributed directly or indirectly by The Dexter Corporation or through payroll deductions or under Social Security.

- periodic benefits for lost income provided under or by (i) any group, franchise or wholesale insurance contract or any other benefit plan or arrangement for which The Dexter corporation has made payroll deductions or contributed (directly or indirectly) to the cost, (ii) any Workers' Compensation Act, non-occupational disability benefits law or similar legislation.

- periodic cash payments (including dependent's benefits, if any) provided under or by Social Security or any other law of the United States, Canada or any state or political subdivision thereof.

* * *

**Who is Eligible**

The Pension Plan covers all full-time employees of the Hysol Division except union employees who have not bargained for coverage under the Plan.

You automatically become a member on January 1 or July 1 following your completion of one year of service, provided you are at least age 25 and under age 60.

The Pension Plan may also cover you if you are a part-time employee. As a part-timer, you become a member at the same time as a full-time employee if you work 1,000 hours during your first 12 months of work. Otherwise, you become a Plan member on January 1 or July 1 following the end of any subsequent anniversary year in which you do work 1,000 hours. (Your anniversary year begins on the day you were hired and ends 12 months later.) For example, if you were hired on April 1, 1978, your anniversary year would be April 1 to March 31. If you worked 850 hours by March 31, 1979, you would not be eligible for the Plan. However, if between April 1, 1979 and March 31, 1980 you worked at least 1,000 hours, your membership would be effective July 1, 1980.

## YOUR COMPANY SERVICE

Your service with the Company is important under this Plan because it affects **when** you receive Plan income and **how much** that income will be.

There are two types of service under this Plan, "Vesting Service" and "Credited Service". Vesting Service determines when you become eligible for benefits, and Credited Service determines how large your benefits will be. Each of these terms will be defined in more detail as they arise in this summary.

## WHEN YOU CAN RETIRE

- **Normal Retirement** – Your Normal Retirement date is the first of the month following your 65th birthday. Although this is the traditional retirement age in the U.S., you may retire earlier or later than this age.

- **Early Retirement** – Upon reaching age 55, you may retire the first of any month after that provided you have at least 10 years of Vesting Service.

- **Deferred Retirement** – If you want, you may work beyond age 65 as long as you continue to perform your job well.

* * *

## SUMMARY PLAN DESCRIPTION FOR A PLAN OF BENEFITS ADMINISTERED BY

## NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY MINNEAPOLIS, MINNESOTA 55440

**Plan Name, and Name and Address of Planholder:**

The Dexter Group Medical and Dental Coverage Plan
The Dexter Corporation
One Elm Street
Windsor Locks, Connecticut 06096

**Name, Address, and Telephone Number of the Plan Administrator:**

Hysol Division
The Dexter Corporation
15051 East Don Julian Road
Industry, California 91749
(818) 968-6511

**Employer Identification Numbers**

**IRS Employer Identification Number:** 060321410
**Plan Number:** 501

**Agent for Legal Process:**

Same as Plan Administrator

**Trustees:** None

**Type of Administration:**

Records maintained by the Employer

**Contribution Payments:**

Employee and Employer contribute

**Plan Year:**

January 1 through December 31

**Claim Procedures:** Please refer to the CLAIM PROCEDURES PAGE.

**Statement of ERISA Rights:** Please refer to STATEMENT OF ERISA RIGHTS page.

**Eligibility and Circumstances Limiting Eligibility:**

As described in the Employee Booklet.

**Type of Plan:**

As described in the Employee Booklet.

**Benefits in Plan:**

See Employee's Coverage and Dependents' Coverage in Employee Booklet.

## SUMMARY PLAN DESCRIPTION

## CLAIM PROCEDURES

1. Claim forms may be obtained from the Plan Administrator or Personnel Department.

2. Northwestern National Life Insurance Company (we) will process the claim and make payment or issue a denial notice.

3. Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. If no notice is received during that period then the claimant can assume the claim was denied and request a review of the denial. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.

4. The notice of denial will be written in an understandable manner and include the following:

   (a) The specific reason(s) for the denial;

   (b) Specific reference to the provision which forms the basis of the denial;

   (c) A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed; and

   (d) An explanation of our claim review procedure.

5. The claimant may request an appeal at any time during the 60 day period following receipt of the notice of denial of the claim.

6. We will consider requests for an appeal of a denied claim upon written application of the claimant or his duly authorized representative. The claimant may, in the course of this appeal, review pertinent documents and submit to us a statement of issues and comments in writing.

7. We will provide the claimant with a written decision providing the final determination of the claim. This decision will be written in an understandable way,

will state the specific reason(s) for the decision and will make specific reference to the provision on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, and usually within 60 days. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary.

## SUMMARY PLAN DESCRIPTION
## STATEMENT OF ERISA RIGHTS

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's Annual Financial Report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people

who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these cost and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions

about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

**SUMMARY PLAN DESCRIPTION FOR A PLAN OF INSURANCE UNDERWRITTEN BY**

**Northwestern National Life Insurance Company Minneapolis, Minnesota 55440**

**Plan Name, and Name and Address of Policyholder:**

The Dexter Group Insurance Plan
The Dexter Corporation
One Elm Street
Windsor Locks, Connecticut 06096

**Name, Address, and Telephone Number of the Plan Administrator:**

Hysol Division
The Dexter Corporation
15051 East Don Julian Road
Industry, California 91749
(818) 968-6511

**Policyholder Identification Numbers**

**IRS Employer Identification Number:** 060321410
**Plan Number:** 501

**Agent for Legal Process:**

Same as Administrator

**Trustees:** None

**Type of Administration:**

Records maintained by Policyholder

**Premium Payments:**

Employee and Employer contribute

**Plan Year:**

January 1 through December 31

**Claim Procedures:** Please refer to CLAIMS PROCEDURES page.

**Statement of ERISA Rights:** Please refer to STATEMENT OF ERISA RIGHTS page.

**Eligibility and Circumstances Limiting Eligibility:**

See Employee's Insurance in Certificate of Insurance.

**Type of Plan:**

As described in the Certificate of Insurance.

**Benefits in Plan:**

See Employee's Insurance in Certificate of Insurance.

## SUMMARY PLAN DESCRIPTION

## CLAIM PROCEDURES

1. Claim forms may be obtained from the Plan Administrator or Personnel Department.
2. Northwestern National Life Insurance Company (we) will process the claim and make payment or issue a denial notice.
3. Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. If no notice is received during that period then the claimant can assume the claim was denied and request a review of the denial. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.

4. The notice of denial will be written in an understandable manner and include the following:

   (a) The specific reason(s) for the denial.
   (b) Specific reference to the provision which forms the basis of the denial.
   (c) A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   (d) An explanation of our claim review procedure.

5. The claimant may request an appeal at any time during the 60-day period following receipt of the notice of denial of the claim.

6. We will consider requests for an appeal of a denied claim upon written application of the claimant or his duly authorized representative. The claimant may, in the course of this appeal, review pertinent documents and submit to us a statement of issues and comments in writing.

7. We will provide the claimant with a written decision providing the final determination of the claim. This decision will be written in an understandable way, will state the specific reason(s) for the decision, and will make specific reference to the provision on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, and usually within 60 days. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if its extension is necessary.

## SUMMARY PLAN DESCRIPTION
## STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement

Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

> Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
>
> Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
>
> Receive a summary of the plan's Annual Financial Report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants. ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you

may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. if you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

## EMPLOYEE BENEFITS

## CASH BONUS/PROFIT SHARING

We've always believed our employees should share in the company's growth. That's why we have a cash bonus/profit sharing plan for our exempt employees. The Human Resources department will explain the particulars to you.

## PENSION, GROUP LIFE INS., LONG TERM DISABILITY, COMPREHENSIVE MEDICAL BENEFITS, BUSINESS TRAVEL

Details of these plans are listed separately in your personal benefits handbook.

## WORKMEN'S COMPENSATION

Of course, you are also entitled to benefits under Workmen's Compensation laws in the state where you work if you are injured on the job. These benefits cover time away from work and medical expenses.

## TUITION REFUND

Many of our employees take high school, college or professional courses in their spare time to improve their job performance and advancement opportunities. We not only encourage this but also provide financial assistance in the form of our educational refund plan. To get all the facts on this program, check with your supervisor or the Human Resources department.

## EMPLOYEE STOCK PURCHASE PLAN

Here's another way you can share in the company's growth – by becoming a part owner of The Dexter Corporation. Under payroll investment plan, regular deductions are made to purchase shares of the corporation's stock. You can get all the details of this program from the Payroll Investment Plan manual.

## SAVINGS PLANS

We have payroll deduction plans for Christmas Club savings and for purchasing U.S. Government Bonds. The Human Resources department has all the details.

## CREDIT UNION

Membership in the Hysol Division, The Dexter Corporation Federal Credit Union is available. The Company participates by making authorized payroll deductions for savings and loans, and provides office space. The Credit Union is an independent organization chartered by the federal government for Hysol people who elect their own officers.

## SERVICE AWARDS

We want you to stay and grow with the company. As a symbol of continuous service to you and your fellow employees. The Dexter Corporation is proud to recognize length of service through presentation of service awards at each five year interval of service.

* * *

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

NO. 89-2030

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MARY JANE WICKMAN,
Plaintiff-Appellant

V.

NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY,
Defendant-Appellee

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# REPLY BRIEF OF PLAINTIFF-APPELLANT

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Richard L. Neumeier
PARKER, COULTER, DALEY & WHITE
One Beacon Street
Boston, MA 02108
(617) 723-4500

* * *

## II. In The Alternative, The Magistrate Erred In Ruling That The Northwestern Policy Constituted A Claim Within The Meaning Of ERISA.

A. On this point Northwestern begins with the incredible assertion that this court's review of the allowance of its motion to dismiss is governed by the clearly erroneous standard(!). (appellee's brief at 14). No case is cited for this remarkable proposition. Since Northwestern was seeking the benefit of the ERISA preemption, the burden was upon it to establish the existence of the plan as Mary Jane noted in her initial brief. (appellant's brief at 32).

Northwestern plays lip service to the proposition that the mere purchase of an insurance policy does not establish a claim within ERISA. (appellee's brief, 15, 16). In addition to the fact that there were periodic premium payments, Northwestern asserts that a plan was established because

> " . . . the allegations . . . reflected that Mrs. Wickman knew that she was an intended beneficiary who was fully aware of the procedure for applying for such benefits. (A. 110-111)." (appellee's brief at 16).

It would be a strange life insurance policy that did not articulate a procedure for the beneficiary to apply for benefits. This court can take judicial notice of the fact that life insurance policies for generations have contained standard provisions setting forth "the procedure for applying for" benefits. The existence of such a procedure is insufficient to establish a "plan" within the meaning of ERISA.

C. Finally, Northwestern argues that there was no harmful error because at trial there was introduced into evidence a document entitled "STATEMENT OF BENEFITS AND POLICIES" prepared by the Dexter Corporation (Dexter). (E. 37) (appellee's brief at 16). Northwestern points out that this STATEMENT contains a detailed description of benefits available to Dexter Corporation employees and then asserts:

> "The life insurance benefits provided by Northwestern were described in an easy-to-read question and answer format. (E. 57-63). A 'summary plan description' of these benefits, including a 'statement of ERISA rights' and a description of 'claim procedures', all is required by 29 U.S.C.

§ 1022, was included in this document. (E. 82-83a)." (appellee's brief, 16, 17).

A review of Ex. 17 indicates that the Dexter Corporation did establish an ERISA plan; however, the life insurance policy purchased from Northwestern was not part of it. Pages E. 82-83a, cited by Northwestern, are decidedly *not* to the claim procedure involving life insurance but rather to medical and dental benefits available to Dexter employees, which was part of an ERISA plan.[4] As to the medical and dental benefits Dexter set forth a right of review, as is required by ERISA. See 29 CFR § 2560.503-1(g). (A. 214).

In stark contrast the excerpt from the "STATEMENT OF BENEFITS AND POLICIES" dealing with the Northwestern life insurance policy (E. 57-63) contains no "statement of ERISA rights" or right of review as required by ERISA. (Compare E. 62a - 62 with E. 82a - 83). The portion of the STATEMENT OF BENEFITS AND POLICIES dealing with life insurance merely states, as is usually required, that written notice of claim be provided and that proof of loss be submitted. (E. 61a - 62).

## Conclusion

Paul did not die as a result of natural causes. Even Northwestern no longer asserts that he took his own life. The Court should order that in failing to pay accidental death benefits Northwestern violated its obligations

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[4] Dexter contracted with Northwestern to provide the medical and dental benefits. (E. 64-83a).

under ERISA and that Mary Jane is entitled to the accidental death benefit, plus prejudgment interest and reasonable attorney's fees and costs. In the alternative, this Court should reverse the order allowing the motion to dismiss the contract claim and order a trial on the merits before a jury.

By her attorneys,

/s/ Richard L. Neumeier
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